

ATTACHMENT, SELF-ESTEEM AND SUBJECTIVE WELL-BEING
AMONG SURVIVORS OF CHILDHOOD SEXUAL TRAUMA

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Table of Contents

Introduction.....	1
Theory of Well-Being.....	2
Attachment Theory.....	3
Childhood Sexual Trauma and Attachment.....	3
Childhood Sexual Trauma and Sexual Self-Esteem.....	4
Attachment and Sexual Self-Esteem.....	5
Attachment and Subjective Well-Being.....	5
Childhood Sexual Trauma and Subjective Well-Being.....	7
Sexual Self-Esteem and Subjective Well-Being.....	8
Hypotheses.....	11
Method.....	12
Participants.....	12
Procedure.....	13
Instruments.....	13
Hypotheses and Data Analysis.....	17
Results.....	19
Discussion.....	27
Summary of Major Findings.....	27
Theoretical Implications.....	30
Practice Implications.....	31
Strengths of the Present Study.....	33
Limitations of the Present Study.....	34
Directions for Future Research.....	35
Summary and Conclusions.....	35
References.....	37
Appendix A.....	46
Statement of the Problem.....	46
Criterion for Inclusion of Studies in Literature Review.....	48
Theory of Well-Being.....	49
Attachment Theory.....	51
Theoretical Integration.....	53
Childhood Sexual Trauma.....	54
Sexual Self-Esteem.....	56
Subjective Well-Being.....	58
Childhood Sexual Trauma and Attachment.....	59
Childhood Sexual Trauma and Sexual Self-Esteem.....	61
Attachment and Sexual Self-Esteem.....	62
Attachment and Subjective Well-Being.....	63
Childhood Sexual Trauma and Subjective Well-Being.....	65
Sexual Self-Esteem and Subjective Well-Being.....	66
Conclusion.....	66

Appendix B	68
Appendix C	71
Appendix D	72
Appendix E	74
Appendix F.....	76
Appendix G.....	77
Appendix H.....	79
Appendix I	80

Attachment, Self-Esteem and Subjective Well-Being Among Survivors of Childhood Sexual Trauma

Childhood sexual trauma, defined as any unwanted sexual act that occurs prior to the age of 18 (Bailey, Moran & Pederson, 2007), can lead to a myriad of difficulties for survivors. Survivors of childhood trauma comprise nearly 30% of all individuals seeking psychological treatment in the United States (Dimitrova et al., 2009). Additionally, individuals who have survived childhood sexual trauma are more likely than those who do not have a history of such trauma to endorse symptomology consistent with depression, PTSD and bipolar disorder (Smith, Gamble, Cort, Ward, He & Talbott, 2011). Survivors of childhood sexual abuse are also more likely to experience further trauma (e.g., victimization from romantic partners) in adulthood as compared to the general population (Riggs, Cusimano & Benson, 2011; Royse et al., 1993).

Survivors of childhood sexual trauma often experience attachment insecurity (Muller et al., 2000) as well as negative thoughts and feelings about themselves, which can lead to worsening psychological distress (e.g., PTSD symptoms; Muller et al., 2000). Additionally, individuals who experience sexual trauma at a young age may be more susceptible to neuronal deficits in attention regulation, impulsive behavior, abnormal fear responses and difficulty in memory consolidation (Sugaya et al., 2012). These problems can lead to difficulty in academic or work performance, social relationships, and daily functioning. In addition, early childhood sexual trauma may lead to problems in adult romantic relationships, especially in relation to sexuality. Sexual self-esteem, or the level at which an individual feels positively about themselves in a sexual manner, has been found to be associated with overall subjective well-being (Mayers et al., 2003).

Theory of Well-Being

Lent (2004) described two models that can be used to assess an individual's degree of subjective well-being. The normative model of well-being is applied to individuals who have not been exposed to trauma, whereas the model of restorative well-being applies to individuals who have experienced an extreme stressor (e.g. trauma). For the purpose of this study, the model of restorative well-being will be utilized to discuss the relationship between childhood sexual trauma, attachment, sexual self-esteem and subjective well-being. According to Lent (2004), social interactions as well as self-efficacy can be strongly associated with recovering from trauma and increasing overall well-being. Thus, personality characteristics such as attachment security can contribute to subjective well-being. In this sense, restorative factors can increase an individual's well-being after a trauma or multiple traumas occur.

As stated by Lent (2004), traumas can be described as “stressful events (or, more specifically, how such events are appraised), which are assumed to create perturbations in people's characteristic levels of domain-specific and overall life satisfaction” (p. 501). According to Lent (2004), individuals who experience trauma are more likely to have difficulty maintaining subjective well-being, unless they have the coping mechanisms in place to attenuate the stressors they face. For example, individuals must be able to set goals for themselves as well as maintain insight into their problems. Through this, individuals will obtain a means of resolving the specific problems that they are coping with. Additionally, the individual must have efficacy regarding their coping mechanisms (Lent, 2004) to assist in recovery from previous sexual traumas. Theoretically, individuals who do not recover from childhood sexual trauma are likely to have insecure levels of attachment, lower levels of sexual self-esteem and decreased subjective well-being.

Attachment Theory

Attachment theory was created as a framework for understanding the relationships between infants and their caregivers (Bowlby, 1973). Hazan and Shaver (1987) extended attachment theory to later life romantic relationships. According Hazan and Shaver, the internal working model explains how the self, including one's self-concept and self-esteem, are influenced by patterns of attachment relationships. Attachment patterns created in infancy are carried into adulthood. Thus, individuals who experience childhood sexual trauma are likely to have experienced insecure attachment both in childhood and in adulthood.

Bartholomew and Horowitz (1991) delineated three attachment styles that are formed by children through repetitive interactions with their caregivers. Securely attached adults have a good sense of self-worth and the ability to form healthy and intimate relationships with others (Bartholomew & Horowitz, 1991). Individuals who have anxious or avoidant attachment styles can be described as having insecure attachment. Further, individuals who maintain insecure attachment into adulthood may have preoccupied patterns of attachment, indicating that they are overly concerned with gaining approval and acceptance from their partners. These individuals often have negative views of themselves and a tendency towards enmeshment or detachment from romantic partners (Bartholomew & Horowitz, 1991). According to Lent (2004), an individual's perception of life events as well as their ability to resolve problems can be influenced by personality characteristics, such as attachment style. Thus, an individual's ability to recover from traumatic experiences is partially contingent on their level of attachment security.

Childhood Sexual Trauma and Attachment

As stated previously, attachment is a trait established during infancy that affects the way we interpret relationships throughout the lifespan (Bowlby, 1973). Congruent with the model of

restorative well-being, attachment is considered to be a trait of our personality, a marker that impacts our perception of the world (Lent, 2004; Bowlby, 1973). The experience of sexual trauma creates a rupture in the working model related to attachment. According to empirical research, individuals who experience childhood trauma are more likely to report attachment insecurity (Alexander, 2009; Bailey, Moran & Pederson, 2007). For example, Alexander (2009) surveyed 93 women survivors of childhood sexual abuse and found that childhood sexual trauma contributes to insecure attachment styles. Insecure attachment can be problematic in adult relationships because it fosters relational problems, hostility, antisocial problems, impulsiveness, passivity, helplessness, lack of empathy, and difficulty having relationships with peers and fostering friendships (Liang, Williams & Siegel, 2006). This is important to understand as future relationships in adulthood may be impacted by trauma that occurred in childhood.

Childhood Sexual Trauma and Sexual Self-Esteem

High levels of sexual self-esteem are associated with healthy sexual relationships (Kelly & Erickson, 2007). In contrast, research has found that childhood sexual abuse has long lasting effects on an individual's sexual self-esteem (Allgeier & Allgeier, 1995; Anderson & Newton, 1997). The link between sexual self-esteem and childhood trauma could be facilitated in part due to the lack of positive and securely attached sexual relationships (Kelly & Erickson, 2007). Thus, childhood sexual trauma can be related to an individual's attachment security in both childhood and with subsequent romantic relationships.

As stated by Mayers et al. (2003), sexual self-esteem is influenced by a history of sexual trauma. Mayers and colleagues utilized five case studies to analyze sexual self-esteem. These researchers found that sexual self-esteem can reduce an individual's view of self, feelings about life and ability to experience pleasure with a partner (Mayers et al., 2003). Particularly, the use of

sexual threats or insults can decrease feelings regarding the person in a sexual manner, thereby decreasing her or his sexual self-esteem. In this sense, it is likely that individuals who experience traumatizing sexual events prior to the age of 18 will be more likely have negative views of their sexuality than individuals who do not experience childhood sexual trauma. As sexual insults can be internalized, this experience can spread to multiple facets of the individual including self-esteem and overall subjective well-being. According to Mayers et al. (2003), damage to sexual self-esteem can cause severe distress and decreased mental health.

Attachment and Sexual Self-Esteem

Sexual self-esteem is comprised of individuals' feelings and cognitions regarding themselves as sexual beings. An analysis of 74 heterosexual participants yielded results that indicated individuals who have high sexual self-esteem tend to engage in healthy relationships, marked by positive and open communication (Oattes & Offman, 2007). In relationships where sexual self-esteem for one or both partners is low, individuals may have more difficulty with communication; however, therapeutic interventions could be employed to promote the development of communication skills and this could increase confidence within one's relationship (Kelly & Erickson, 2007). Securely attached individuals may have an advantage over insecurely attached individuals because they are more likely to have strong levels of trust and communication with their romantic partner, even if sexual self-esteem is low (Hazan & Shaver, 1987). However, damage to sexual self-esteem remains a threat to romantic relationship satisfaction and overall well-being for many individuals.

Attachment and Subjective Well-Being

Subjective well-being is the way in which individuals perceive their life, either positive or negative. According to a study by La Guardia, Ryan, Couchman and Deci (2000) attachment

security is associated with higher levels of overall subjective well-being. This study analyzed responses from 152 undergraduate students to better understand if the association between attachment and subjective well-being is consistent across the life-span. Further, these researchers investigated an individual's attachment style both between and within multiple relationships (e.g., friendships, family relationships, romantic relationships, relationships with parents). Results from the study indicated that when an individual has one relationship that is problematic, it does not impact overall attachment style or well-being. Instead, an individual's perception of multiple relationships impacts the way they view their external world (La Guardia et al., 2000). Therefore, secure attachment across multiple relationships is associated with subjective well-being rather than attachment within one specific relationship.

Additional research conducted by Jiang, Huebner and Hills (2013) found similar results. In their study, 201 middle school students were assessed to understand the mediating factor of hope between attachment and life satisfaction. Research assessing the relationships between adolescents' parental attachment and subjective well-being found that more autonomy and separation from parents could lower subjective well-being for children as the transition from childhood to adolescence. Consequently, secure parental relationships yielded higher levels of subjective well-being (Jiang, Huebner & Hills, 2013). Kirchmann et al., (2013) interviewed 81 individuals between the ages of 69 and 73 years of age to assess attachment styles and additional demographic variables. Findings from this study were consistent with other findings stating attachment is associated with subjective-well being despite sociodemographic characteristics such as, age, SES, coping strategies and medical problems (Kirchmann et al., 2013).

Childhood Sexual Trauma and Subjective Well-Being

Finkelhor and Brown (1985), proposed that childhood abuse of any type is a violation of trust and boundaries. This can be destructive and cause significant psychological distress among those exposed. Becker-Lausen, Sanders and Chinsky (1995) studied 301 undergraduate students in the Northeastern United States to better understand the effect of childhood abuse on negative perceptions of life. Results from this study found that childhood abuse was associated with negative perceptions of life independent of gender. This indicates that both male and female participants who had experienced childhood abuse can experience depression and dissociations in adulthood. In addition Becker-Lausen et al., (1995) indicated that survivors of childhood abuse are likely to experience re-victimization in adulthood. In addition, these individuals have problems maintaining secure interpersonal relationships in adulthood (whether those be romantic in nature or not).

A meta-analysis of previous literature on sexual assault found that increased levels of sexual abuse history can cause poor health status, including behavioral, psychological, psychophysiological and neuroanatomical problems, which will decrease overall levels of subjective well-being (Leserman, 2005). In comparison, adults who have positive childhood experiences often have very high levels of life satisfaction, indicating that individuals who experience childhood sexual trauma may experience lower levels of subjective well-being (Hinnen, Sanderman & Sprangers, 2009). In their study, Hinnen et al., (2009) surveyed 437 participants, primarily female, to assess family context, parental behavior, childhood adversities (i.e. divorce, neglect, abuse), adulthood attachment style and life satisfaction. Results from a regression analysis indicated that childhood memories contributes to adult attachment which in turn

contributes overall subjective well-being (Hinnen et al., 2009). For example, individuals who have history of abuse in childhood are shown to have lower levels of attachment security.

Sexual Self-Esteem and Subjective Well-Being

Subjective well-being is the “global feeling of contentment, fulfillment, or happiness with life in general” (Perrone & Civileto, 2004 p. 107). According to the Theory of Well-Being (Lent, 2004), secure attachment will increase an individual’s subjective well-being as well as the ability to recover from negative life events and previously damaged well-being. In a study conducted by Gnilka et al., (2013), 190 participants were surveyed to better understand the relationship between depression, hopelessness, life satisfaction and adult attachment. Results from this study indicate that satisfaction and pleasure from life occur when one feels excited about future tasks and goals. Results also indicate that individuals who have close intimate relationships have higher levels of life satisfaction than individuals with poor romantic relationships. As social beings, people crave secure attachment relationships from an early age and throughout the lifespan.

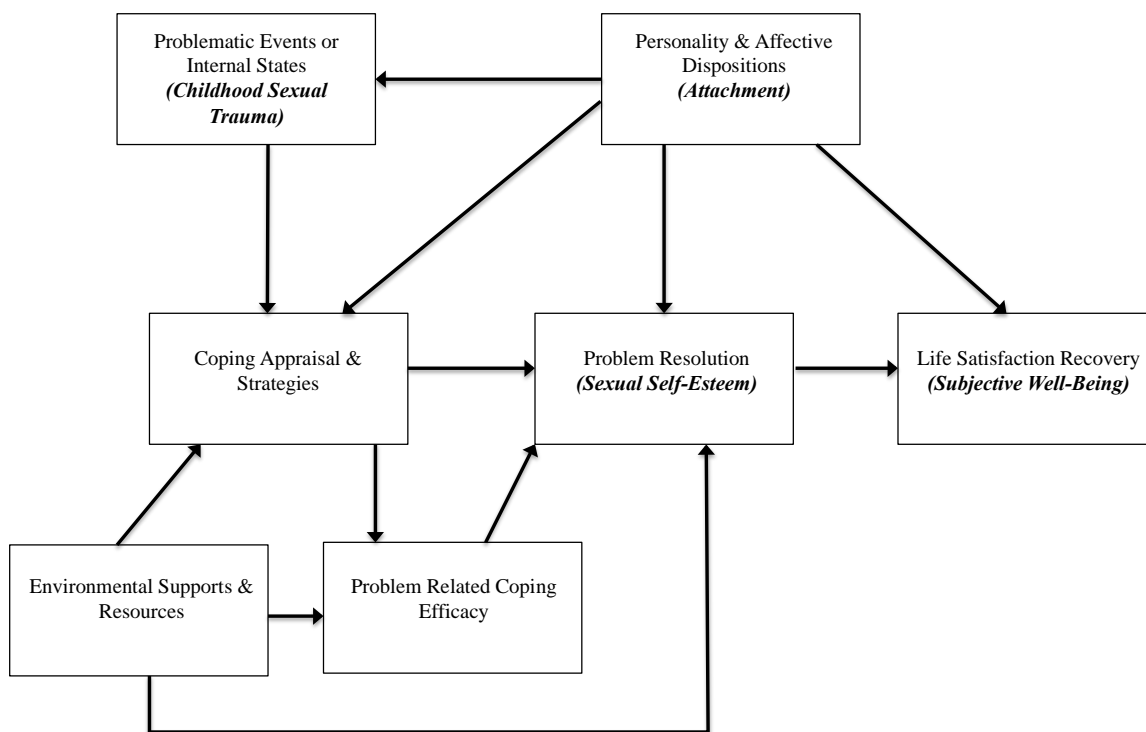
Purpose of the Study

To summarize, it is believed that attachment theory and the theory of well-being can shed light on an individual’s well-being. Given the challenges faced by survivors of sexual trauma (e.g., revictimization, mental health symptoms) it is important to analyze the impact that sexual trauma has on overall well-being. The purpose of the current study is to analyze the relationship between the intensity of childhood sexual trauma, attachment style and sexual self-esteem on the dependent variable of subjective well-being. The aforementioned research has indicated that secure levels of attachment, lack of sexual trauma during childhood and higher levels of sexual self-esteem will contribute to higher levels of subjective well-being (Gnilka et al., 2013; Hinnen

et al., 2009; Becker-Laussen et al., 1995). First, it was predicted that higher attachment security would be related to greater subjective well-being, based on previous research which found that higher levels of secure attachment were associated with global well-being (La Guardia et al., 2000; Jiang et al., 2013). In addition, according to the model of restorative well-being, personality characteristics such as attachment are directly associated with the restoration of subjective well-being after the experience of a stressor (Lent, 2004). Second, it was predicted that lower scores on a measure of the intensity of childhood sexual trauma would be related to greater subjective well-being, based on previous empirical research. For example, Leserman (2005) found that survivors of sexual trauma experienced lower levels of subjective well-being. In addition, research has shown that individuals who experience childhood sexual trauma are more likely to have insecure attachment, which is related to lower well-being (Hinnen et al., 2009). Third, it was predicted that higher sexual self-esteem would be related to greater subjective well-being, based on past research that has shown sexual and relationship satisfaction contribute to subjective well-being (Gnilka et al., 2013). According to Lent (2004), factors such as increased self-esteem can contribute to subjective well-being. Figure 1 below depicts the interaction between these constructs according to the model of restorative well-being (Lent, 2004).

Figure 1

Path Model of Restorative Well-Being Utilizing the constructs of Childhood Sexual Trauma, Attachment, Sexual Self-Esteem and Subjective Well-Being



Hypotheses

The present study examined relationships between childhood sexual trauma, attachment security, sexual self-esteem, and subjective well-being.

Hypothesis 1: The predictor variables of attachment, childhood sexual trauma, and sexual self-esteem will significantly predict ratings of subjective well-being.

Hypothesis 2: Higher attachment security would be related to greater subjective well-being.

Hypothesis 3: Lower scores on a measure of the intensity of childhood sexual trauma would be related to great subjective well-being.

Hypothesis 4: Higher sexual self-esteem would be related to greater subjective well-being.

Method

The following methods were utilized to investigate the relationship between attachment, childhood sexual trauma, sexual self-esteem and subjective well-being.

Participants

Power analysis indicated a minimum of 112 participants were needed to have an $\alpha = .05$, an effect size of .15 and power of 90% in the present study. Participants were required to be at least 18 years of age. Both male and female students were invited to participate. A total of 257 college students from a mid-sized Midwestern university participated in the study; of these, 30 participants were excluded because they did not complete 2 or more of the scales required for the study. Ten participants were excluded because they did not complete demographic information including the question regarding perceived previous childhood sexual trauma.

The remaining sample was comprised of 217 students; 19.4% were male ($n=42$), 79.3% female ($n=172$), .5% identified their gender as non-binary ($n=1$), .5% identified as gender fluid ($n=1$), and .5% identified as gender queer ($n=1$). Of the 217 participants, 53% reported being in a romantic relationship ($n=115$). Average length of relationship was approximately one and one-half years ($X = 1.47$, $SD = 3.809$). The mean student age was 22 years ($sd=5.894$). The students' class rankings were as follows: 12.4% Freshman ($n=27$), 16.6% Sophomore ($n=36$), 30.9% Junior ($n=67$), 23.0% Senior ($n=50$), 6.5% Senior + ($n=14$), 10.1% graduate student ($n=22$) and .5% other ($n=1$). In addition, 81.1% of participants identified as Caucasian/White ($n=176$), 11.1% African American/Black ($n=24$), .5% Asian American/Asian ($n=1$), 3.7% Hispanic/Latino(a) ($n=8$), 2.8% Bi-racial ($n=6$) and .9% other ($n=2$).

Procedure

Participants were recruited from the Counseling Psychology and Guidance Services Department research pool and via an invitation email through the ALLBSU listserve. Participants were directed to a website hosted by Qualtrics, an online assessment system, where they were presented with an informed consent waiver in which consent was indicated by clicking the link to the survey. The survey included a brief demographic questionnaire and scales measuring adult attachment, childhood sexual trauma, sexual self-esteem and subjective well-being. The scales were presented in a counterbalanced and random order to reduce threats to internal validity (e.g., order effects/maturation). All responses were anonymous and stored on a password-protected secure device available only to the primary researchers. Individuals retained the right to discontinue participation in the study at any time. After completion of the survey, participants were directed to a debriefing form that included information about university counseling services.

Instruments

Demographic Questionnaire. Participants completed a brief demographic questionnaire in order for the researchers to better understand and describe the population being studied. Participants were asked to provide self identified gender, age, sexual orientation, year in school, ethnicity, nationality, academic major, and childhood sexual trauma experience.

Childhood Trauma Questionnaire. (CTQ; Bernstein & Fink, 1998) The scale utilized to assess childhood sexual trauma was the CTQ. The CTQ is a 28-item, self-report, Likert-type scale used to assess the presence of emotional, physical and sexual abuse. The scale is comprised of five subscales. Each of these subscales contains five questions, as well as three additional questions that measure neglect and minimization or denial of symptoms. The five-point Likert

type scale consists of items from “never true” to “very often true.” Most questions are phrased to assess specific behaviors or abusive interactions that occurred prior to the age of 18. For example, “When I was growing up, someone touched me in a sexual way or made me touch them” (Bernstein & Fink, 1998). Each scale contains a specific threshold. If a participant ranks above said threshold, he or she classified as experiencing said abuse. The thresholds are as follows: emotional abuse = 10, physical abuse = 8 and sexual abuse = 8. The Childhood Trauma Questionnaire has test-retest reliability coefficients ranging from .79 to .86 over a four-month period (Bernstein & Fink, 1998). Convergent validity was demonstrated through comparison with clinical interviews to assess trauma symptoms such as PTSD or anxiety (Bernstein et al., 1994; Bernstein et al., 2003; Walker et al., 1999). The CTQ also has high internal consistency when utilized with known survivors of trauma (Cronbach’s $\alpha = .80$ to $.94$ for the sexual abuse subscale; Midei et al., 2013). For the purpose of this study, only the five-item sexual abuse subscale was analyzed as this study focuses specifically on childhood sexual trauma. A sample item of this scale is: “When I grew up I believe I was sexually abused.” Higher scores on this scale indicate higher intensity of childhood sexual trauma. Scores from this subscale were added together to find the participants intensity of trauma. All participants were included in the current study. Cronbach’s α for the sexual abuse subscale was $.94$ in the normed sample (Bernstein & Fink, 1998; Scher, Stein, Asmundson, McCreary & Ford, 2001). Cronbach’s α for this scale in the present study was $.893$. A three-month test-retest found a correlation of $.81$.

The Experiences in Close Relationships Scale – Revised. (ECR-R; Fraley, Brennan & Waller, 2000) was utilized to measure attachment security. The ECR-R measures two facets of attachment: avoidance and anxiety. Absence of avoidant and anxious attachment indicates the presence of secure attachment on this scale. The ECR-R is a 36-item Likert-type scale in which

respondents rate their agreement on items from 1 (strongly agree) to 5 (strongly disagree). Scores are achieved by first reverse scoring (items 9, 11, 20, 22, 26, 27, 28, 29, 30, 31, 33, 34, and 36) then summing the scores. The subscales consist of a 36-item avoidance scale and a 36-item anxiety scale. A sample item from the avoidance scale is “I get uncomfortable when a romantic partner wants to be close.” A sample item from the anxiety scale is “I am afraid I will lose my partner’s love.” Each subscale score can range from 9-45; the lower the score, the more the respondent is experiencing anxiety or avoidance. The ECR-R has significant one-year test-retest reliability for the anxiety subscale (.94) and the avoidance subscale (.95) for undergraduate students (Fraley et al., 2000). The full scale showed significant internal consistency with Cronbach’s alpha of higher than .90 (Fairchild & Finny, 2006). Discriminant validity was also supported, as no relationship was established between social desirability and the ECR-R (Fairchild & Finny, 2006). Convergent construct validity was established with the ECR-R and the UCLA Loneliness Scale, $r = .53$ for undergraduates as the scales are utilized to measure different constructs (Fairchild & Finney, 2006). Scoring on the ECR-R requires researchers to combine and reverse scores on the anxiety and avoidance questionnaire. The overall score will be a reflection of the participants’ attachment security. The Cronbach’s alpha score for the current study was .93.

The Multidimensional Sexuality Questionnaire. (MSQ; Snell, Fisher & Walters, 1993)

The MSQ was utilized to measure sexual self-esteem. This scale is a 60-item, Likert-type questionnaire utilized to measure twelve different facets of human sexuality. These include: sexual-esteem, sexual preoccupation, internal sexual control, sexual consciousness, sexual motivation, sexual anxiety, sexual assertiveness, sexual depression, external sexual control, sexual monitoring, fear of sex and sexual satisfaction. Respondents answered questions on a

five-point scale where 0 indicates “not at all characteristic of me” and 4 is indicative of “very characteristic of me.” Scores on the 12 subscales range from 0 to 20. Scoring the MSQ requires researchers to first reverse code the following items: 19, 31, 47 and 50. The MSQ score is found by summing up the items to get both subscale and total scores. For the purpose of this study, all subscales on the MSQ were collected to maintain scale integrity. However, the sexual-esteem scale was the only subscale analyzed, as it is the scale that best fits the purpose of the study. Cronbach’s alpha was found in a university population. Scores on the MSQ subscales ranged from .63 to .94 dependent on the subscale (Snell et al., 1993). On the Sexual Esteem subscale, Cronbach’s alpha was .87 for the college student normed sample (Snell et al., 1993). The Cronbach’s alpha score for the present study was .88. Test-retest reliability for the sexual esteem subscale was .85 for a University population (Snell et al., 1993). Construct validity was found by comparing scores on the MSQ sexual self esteem subscale to sexual attitudes and communal approaches to sexual relationships among college students (Fisher & Snell, 1995).

Brief Multidimensional Students’ Life Satisfaction Scale. (BMSLSS; Seligson, Huebner, & Valois, 2003) The instrument utilized to measure subjective well-being was the BMSLSS. The BMSLSS is a six-item questionnaire that measures how satisfied college students are in various domains of life. Responses are recorded on a 7-point scale, on which a score of 1 is equivalent to “terrible” and 7 is equivalent to “delighted.” High scores on the BMSLSS are equivalent to greater levels of subjective well-being. Sample questions include: “I would describe my satisfaction with my overall life as...” and “I would describe my satisfaction with myself as ...” Internal consistency for this scale was .75 for the BMSLSS total score (Seligman et al., 2003). Researchers found concurrent validity through correlations with the long version of the Multidimensional Student’s Life Satisfaction Scale (MSLSS) ($r=0.66$) as well as the Student

Subjective well-being Scale (SLSS) ($r=0.62$). Convergent validity was found comparing the BMSLSS with the Multidimensional Student Life Satisfaction Scale. Subscales were found to range between a Cronbach's alpha of .47 (self subscale) and .60 (life subscale) for the high school normed sample (Seligson et al., 2003). In the present study, Cronbach's alpha was .83.

Hypotheses and Data Analysis

It was hypothesized that the predictor variables of attachment, childhood sexual trauma, and sexual self-esteem would together account for a significant amount of variance in the criterion variable of subjective well-being and that each would make a significant individual contribution to subjective well-being. Specifically, I hypothesized higher secure attachment; lower scores on a measure of childhood sexual trauma, and higher sexual self-esteem would contribute to higher subjective well-being. Participants with greater attachment security would have higher sexual self-esteem and higher subjective well-being. In order to test hypotheses in the present study, a hierarchical regression was utilized. A hierarchical regression was selected as the appropriate statistical test based upon the theory and hypotheses. Specifically, the researchers wanted to investigate the effect of three independent variables on one dependent variable (Pedhauzer, 1997). Factors that effect the significance of regression includes the sample size, outliers and the range of values selected (Pedhauzer, 1997). Participants who didn't complete more than two scales were excluded from the study. Any additional missing data was filled in with the mean score of the data set.

Assumptions of hieracrchical regression include: 1) variables are normally distributed, 2) the relationship is linear, 3) variables are reliably measured, and 4) homoscedacity of error variance. Each of these assumptions was met in the current study.

Attachment was entered at step one of the regression in accordance with Lent's (2004) model of restorative well-being. According to Lent (2004) personality and affect dispositions affect individual's perceptions of problematic events (e.g., trauma), problem resolution (e.g., sexual self-esteem) and life satisfaction recovery (e.g. subjective well-being). The model of restorative well-being states that personality characteristics such as attachment can contribute to perceptions of all other aspects of life, therefore it is placed first.

The presence of childhood sexual abuse was entered at step two. According to the model of restorative well-being, problematic or stressful events such as childhood sexual trauma creates distress and can lower an individual's subjective well-being as well as problem resolution and perceptions of the self (Lent, 2004).

Adult sexual self-esteem was entered in the third and final stage of the current hierarchical regression. Lent's (2004) theory states that both personality characteristics and stressors contribute to problem resolution. Ergo, the presence of problematic events such as childhood sexual trauma as well as attachment style can contribute to the resolution of a specific problem (Lent, 2004). Thus, sexual self-esteem is the final step impacting subjective well-being.

Results

Means and standard deviations for the variables in the present study are shown in Table 1. The mean score for the ECR-R in the present study was 2.39 (SD=.97) which was roughly commensurate with the mean score of the normed sample which was 2.95 (SD=.94) (Wongpakaran & Wongpakaran, 2012). The mean score for the BMSLSS in the present study was 5.12 (SD=.98) as compared to the normed sample which was similar, although slightly higher at 5.75 (SD=.96) (Seligson et al., 2003). The mean score for the MSQ Sexual Esteem subscale was 14.87 (SD=5.58), which was comparable to the normed sample, which was 13.17 (Snell, Fisher & Walters, 2015). The mean score for the CTQ Sexual Abuse subscale was 7.75 (SD = 5.68), which was comparable to the normed sample to Scher et al.'s (2001) mean 5.45 (SD = 2.14). Examination of Cronbach's coefficient alpha revealed acceptable levels of internal consistency for all scales in the current study (α coefficients ranged from .72 to .93; See Table 1 for a complete listing of internal consistency estimates). In addition, a correlational matrix was created to better understand the relationships between the variables in the present study. As seen in Table 2, all scales used to measure the predictor variables (ECR-R Total score for attachment security; MSQ Sexual Esteem Subscale and CTQ Sexual Abuse Subscale) were significantly correlated with the BMSLSS (subjective well-being) total score. Results from the correlational analysis indicated that attachment positively significantly correlated with Subjective Well-Being ($r = .43, p < .01$), meaning that participants with greater attachment security also had higher subjective well-being. Attachment was also significantly positively correlated with Sexual Self-Esteem ($r = .37, p < .01$), indicating participants with greater attachment security also had higher sexual self-esteem and attachment was negatively significantly correlated with childhood sexual trauma ($r = -.29, p < .01$), indicating individuals with greater attachment security had lower

scores on a measure of childhood sexual trauma. In addition, sexual self-esteem was significantly positively correlated with subjective well-being ($r = .28, p < .01$), indicating individuals with higher self esteem also perceived higher subjective well-being for themselves. Childhood sexual trauma was significantly negatively correlated with subjective well-being ($r = -.32, p < .01$), indicating individuals with lower scores on a measure of childhood sexual trauma were more likely to report higher subjective well-being. Finally, childhood sexual trauma was negatively significantly correlated with sexual self-esteem ($r = -.15, p < .01$), indicating that individuals with higher scores on a measure of childhood sexual trauma were likely to have lower sexual self-esteem.

Participants in the current study were asked to answer a validity question regarding the presence of childhood sexual trauma in the demographics section of the study. Participants who answered yes ($n=73$) to experiencing sexual trauma during childhood yielded higher scores on the CTQ Sexual Abuse Subscale ($X=12.36, SD=7.42$) than those who didn't report experiencing childhood sexual trauma ($X=5.42, SD=2.16$). Therefore, the validity check was suitable because scores on the subscale were higher for those who noted that they had experienced trauma in childhood. However, it should be noted that the standard deviation for this group is much higher than the non-sexual trauma group. This may be due to the wide range of experiences survivors of sexual trauma may have experienced.

Table 1*Summary Table of Scale Properties*

	α	X	SD
ECR-R Total	.930	2.39	.97
BMSLSS Total	.826	5.12	.98
MSQ Sest Total	.884	14.78	5.58
CTQ SA Total	.725	7.75	5.68

Note. α = Cronbach's Alpha; X = Mean; SD = Standard Deviation

ECR-R = Total Score Experiences in Close Relationships Questionnaire - Revised

BMSLSS Total = Total Score in Brief Multidimensional Student's Life Satisfaction Scale

MSQ Sest Total = Total Score in Multidimensional Sexuality Questionnaire Sexual Esteem Subscale

CTQ SA Total = Total Score in Childhood Trauma Questionnaire Sexual Abuse Subscale

Table 2*Summary Table of Intercorrelations*

	(1)	(2)	(3)	(4)	(5)
ECR -R Total	(1) 1.00				
BMSLSS Total	(2) .434**	1.00			
MSQ Sest Total	(3) .366**	.283**	1.00		
CTQ SA Total	(4) -.289**	-.318**	-.145*	1.00	
Gender	(5) .110	-.030	-.144*	.005	1.00

Note: ECR-R = Total Score Experiences in Close Relationships Questionnaire - Revised

BMSLSS Total = Total Score in Brief Multidimensional Student's Life Satisfaction Scale

MSQ Sest Total = Total Score in Multidimensional Sexuality Questionnaire Sexual Esteem Subscale

CTQ SA Total = Total Score in Childhood Trauma Questionnaire Sexual Abuse Subscale

Gender = Participants Gender

**, Correlation is significant at the 0.01 level (2-tailed).

*, Correlation is significant at the 0.05 level (2-tailed).

A three-stage hierarchical regression model was utilized to measure the contributions of predictor variables to the criterion variable of subjective well-being and to test the hypotheses in the present study (Pedhauzer, 1997). The theoretical rationale for this analysis is found within Lent's (2004) model of restorative well-being.

It was hypothesized that the predictor variables of attachment, childhood sexual trauma, and sexual self-esteem would together and individually account for a significant amount of variance in the criterion variable of subjective well-being. This is due to the relationship between the variables and the model of restorative well-being (Lent, 2004). Lent's (2004) theory states that personality, stressors and perceptions of self/problem resolution contribute to global feelings of well-being. In addition, variables were entered in chronological order because attachment is first formed in infancy, whereas childhood sexual trauma occurs prior to the age of 18, and current sexual self-esteem for the adult participants would be subsequent to both attachment and childhood sexual trauma. Further, a theoretical rationale is provided regarding the ordering of the variables.

Attachment was entered at Step One of the regression analysis. This construct is first, based on Lent's (2004) model of restorative well-being. In his model, personality and affect dispositions affect how individual's perceive problematic events such as childhood sexual trauma. In addition, attachment contributes to one's ability to participate in problem resolution (e.g., sexual self-esteem) and life satisfaction recovery. According to Lent (2004), personality/affective dispositions, such as attachment styles, can affect the frequency and intensity individuals can understand their environment, including experiences of trauma. In addition, personality characteristics influence the effectiveness of coping strategies; thereby, impacting the recovery process and overall subjective well-being (Lent, 2004).

The presence of childhood sexual abuse was entered at Step Two of the hierarchical regression. Problematic events such as childhood sexual trauma affect problem resolution and life satisfaction recovery (Lent, 2004). According to the model of restorative well-being, problematic or stressful events such as childhood sexual trauma create perturbations in an individual's overall subjective well-being and can decrease problem resolution based upon an individual's perception of stress severity. Thus, childhood sexual-trauma was indicated prior to sexual self-esteem.

Adult sexual self-esteem was entered in the third and final stage. Lent's (2004) theory states that the constructs associated with attachment as well as constructs that effect childhood sexual trauma have an effect on problem resolution. The presence of problematic events such as childhood sexual trauma can only be recovered through coping strategies and resolution of a specific problem (Lent, 2004). Thus, sexual self-esteem is the final step impacting subjective well-being.

Results of the regression analysis are presented in Table 3.

Table 3*Summary of Hierarchical Regression Analysis for Variables predicting Subjective Well-Being*

Variable	b	t	p	sr ²	R	R ²	DR ²
Step 1					0.434	0.188	
ECR-R Total	0.434	7.061	0.00	0.434			
Step 2					0.478	0.229	0.04
ECR-R Total	0.373	5.95	0.00	0.377			
CTQ Sexual Abuse Total	-0.21	-3.34	0.001	-0.223			
Step 3					0.494	0.244	0.015
ECR-R Total	0.326	4.92	0.00	0.319			
CTQ Sexual Abuse Total	-0.204	-3.28	0.001	-0.219			
MSQ Sexual Esteem Total	0.134	2.09	0.038	0.142			

Note: N = 217

ECR-R = Total Score Experiences in Close Relationships Questionnaire - Revised

CTQ SA Total = Total Score in Childhood Trauma Questionnaire Sexual Abuse Subscale

MSQ Sest Total = Total Score in Multidimensional Sexuality Questionnaire Sexual Esteem Subscale

First, it was hypothesized that the predictor variables of attachment, childhood sexual trauma, and sexual self-esteem would together account for a significant amount of variance in the criterion variable of subjective well-being. Examination of the multiple R^2 revealed that the three predictor variables together accounted for 24.4% of the variance, and provided support for the first hypothesis.

Second, it was hypothesized that higher attachment security would be related to higher subjective well-being. At Step One, attachment contributed significantly to the variance in subjective well-being, and accounted for 18.8% of the variance, thus providing support for the second hypothesis.

Third, it was hypothesized that lower scores on a measure of childhood sexual trauma would be related to higher subjective well-being. Examination of the ΔR^2 at Step Two with the introduction of the childhood sexual abuse variable indicated a significant change ($\Delta R^2=.04, p <.01$). Childhood sexual abuse accounted for an additional 4% of the variance in subjective well-being at this step. Thus, the third hypothesis was supported.

Finally, it was hypothesized that higher sexual self-esteem would be related to higher subjective well-being. Examination of the ΔR^2 at Step Three when the variable of sexual self-esteem was entered indicated a significant change ($\Delta R^2=.015, p <.01$). Sexual self-esteem accounted for an additional 1.5% of the variance in subjective well-being. Thus, the final hypothesis was supported as well. The meaning of these findings in the context of theory and existing empirical literature will be discussed in the following section.

Discussion

The current study investigated the relationship between childhood sexual trauma and later life levels of subjective well-being as a means of providing clinicians and researchers with greater insight into adult survivors' treatment in psychotherapy. It was hypothesized that higher levels of attachment security, lower scores on a measure of childhood sexual trauma, and higher sexual self-esteem would contribute to higher levels of subjective well-being. Based on attachment theory (Bowlby, 1973) and the model of restorative well-being (Lent, 2004) as well as existing knowledge based on past empirical studies, it was hypothesized that the presence of childhood sexual trauma would be related to lower levels of sexual self-esteem and lower levels of subjective well-being, whereas greater attachment security would be positively related to higher levels of sexual self-esteem and higher levels of subjective well-being.

Summary of Major Findings

Findings from the present study provided support for the hypotheses. First, greater levels of attachment security were related to higher subjective well-being. This is consistent with previous research, which has found that increased levels of independence lower attachment experiences and subjective well-being. For example, Jiang et al., (2013) studied early adolescents' who were attending grades 6-8 and found a direct relationship between attachment security and subjective well-being, such that higher attachment security related to higher subjective well-being. Both this finding and the findings of the present study are consistent with attachment theory, in which it is postulated that attachment in childhood influences later attachment through the internal working model (Hazan & Shaver, 1987). In order to have a significant influence on relationships, attachment patterns should have been repetitive and consistent such that the influence of attachment security pervades all adult relationships. A study

conducted on 136 undergraduate students found that attachment style is a global construct, which is not dependent on one relationship. To speak further, an argument with a friend or even one unsatisfying friendship overall will not have as pervasive an influence as the global internal working models of attachment that are applied to all relationships (La Guardia et al., 2000). Thus, when discussion of attachment security, refers to a global variable that applies to all relationships.

Second, in the present study, participants with higher sexual self-esteem also reported higher subjective well-being. These findings build on previous research that demonstrated a link between general self-esteem and subjective well-being (Moin et al., 2009). Moin and colleagues compared women with physical disabilities and women without physical disabilities in relation to sexual identity, body image and life satisfaction. The researchers found that the way individuals feel about our sexual selves influences the manner in which we perceive our lives (Moin et al., 2009). In an additional study, Moksnes and Espnes (2013) assessed secondary school students in Europe found that general self-esteem contributed to subjective well being across participants with different gender, age, stress, subjective health and chronic mental health conditions. As general self-esteem is comprised of many types of self-esteem, it can be postulated that sexual self-esteem would also contribute to subjective well-being.

Consistent with Lent's (2004), restorative feeling of well-being, problem resolution (i.e. sexual self-esteem) contributes to recovery of subjective well-being or life satisfaction because the way we feel about different aspects of life impact the manner in which we understand life overall. Therefore, the way an individual feels about himself or herself as a sexual being influences their overall well-being. Although there has been minimal empirical research assessing the relationship between sexual self-esteem and subjective well-being there is

empirical support describing the relationship between overall self-esteem and subjective well-being. As components of self-esteem comprise our overall levels of sexual self-esteem it can be postulated that sexual self-esteem influences subjective well-being (Moin et al., 2009).

Third, in the present study, participants who reported experiencing intense childhood sexual trauma reported lower subjective well-being in adulthood. This supported my proposed hypothesis and was also consistent with previous researchers who provided evidence of a link between childhood sexual trauma and psychological distress. Becker-Lausen et al. (1995) analyzed 301 undergraduate students on interpersonal relationships and victimization. This study found that the presence of childhood maltreatment or abuse causes higher levels of dissociation and depression (Becker-Lausen et al., 1995). This can impact global psychological well-being. Other studies have also found that individuals who experience childhood sexual trauma are likely to have symptoms of depression, PTSD, anxiety, dissociations (Leserman, 2005; Smith et al., 2011). A sample of women experiencing major depression and childhood sexual abuse was assessed on their social maladjustment, depression and death ideation. Results from this study yielded those women who experience childhood sexual trauma had a high rate of suicidal behaviors. These individuals displayed higher levels of problems with social and leisure time including intimate or peer relationships (Smith et al., 2011). In addition, a review of literature found individuals who experience childhood trauma are likely to re-victimized in adulthood which also impacts overall levels of subjective well-being (Leserman, 2005).

The finding from the present study indicates that high levels of sexual self-esteem are associated with attachment security were consistent with Oattes and Offman's (2007). Results from Oattes and Offman (2007) study indicated that sexual communication in intimate relationships enhances an individual's feeling about those sexual acts. These results indicate that

strong romantic relationships, which have positive and open lines of communication, can result in increased perceptions of the individual's sexuality. Further, an individual's perception of himself or herself as a sexual being is influenced by the relationship they have with others. In addition, previous researchers have reported that damage to sexual self-esteem can cause someone to experience high levels of distress, problems with mental health and decreased satisfaction with life (Mayers et al., 2003). Further, the current study showed that childhood sexual abuse can negatively affect sexual self-esteem and lowered feelings of self-worth and satisfaction with life.

Theoretical Implications

The results of the current study provide support for both attachment theory (Bowlby, 1973) and the model of restorative well-being (Lent, 2004).

According to Bowlby (1973), relationships established in the first years of life create a working model for how we form relationships in later life. This includes how individuals view themselves, their relationships and themselves in relation to others. Through this internal working model for relationships, individuals engage in adult relationships in a manner that is congruent with their attachment style. Ergo the lens through which individuals view the world is colored by their attachment style, making it a primary characteristic of the person's identity. In other words, people perceive positive and negative life events based upon their understanding of relationships with others (Bowlby, 1973; Lent, 2004). For example, a family death may be viewed as either positive or negative dependent on an individual's attachment style. As found in the current research, individuals who have experienced childhood sexual trauma have a tendency to experience insecure attachment. Due to these results, it is evident that establishing a secure attachment style early in life is essential to maintaining healthy subjective well-being.

Attachment theory specifically assesses whether individuals feel secure, anxious or avoid close relationships altogether, no matter their desire to have close relationships.

The model of restorative well-being (Lent, 2004) states that stressful events have consequences on our perceptions of life and subjective well-being. These consequences can be minor, such as a brief change in mood or a major consequence such as substantial changes in personal identity and worldview. The combination of attachment, childhood sexual trauma and sexual self-esteem account for changes in subjective well-being. In addition, sexual self-esteem and subjective well-being are higher when there is a presence of secure attachment. In addition to an external stressor, internal life perceptions including personality characteristics and feelings of the self can substantially affect an individual's subjective well-being (Lent, 2004). Therefore, coping strategies can be essential in increasing an individual's perceptions of himself or herself. Perceptions of the self can include characteristics such as sexual self-esteem, which can be increased and decreased through specific coping techniques and environmental supports such as therapy. As self-esteem is a contributor to subjective well-being, it is understandable that a way individuals feel about themselves in a sexual manner is reflective of their overall feelings of well-being. In addition, high levels of well-being after a stressor or trauma can impact the manner in which we interpret ourselves in our world, thereby impacting traits such as sexual self-esteem. Encouraging healthy attachment in children promotes healthy and positive interactions between individuals as they grow and create meaningful relationships throughout their lifespan (Bowlby, 1973).

Practice Implications

The findings of the present study have implications for mental health practitioners as they work with childhood survivors of sexual trauma. First, results from this study indicate that

protective factors such as attachment and sexual self-esteem can contribute to higher levels of subjective well-being. Past research has demonstrated that techniques such as journaling and expressive writing have been found to aid symptom reduction for survivors who experience symptoms of PTSD, depression, and anxiety (Meston, Lorenz & Stephenson, 2013). Based on the results of the current study, counseling interventions for survivors of childhood sexual abuse could focus on increasing sexual self esteem and increasing attachment security for this population in order to promote overall subjective well-being. Previous researchers have found that individuals with lower sexual self-esteem can benefit from psychological treatment (Mayers et al., 2003). For example, counselors could promote increased sexual self-esteem by working on relationship skills with individual clients or working directly on improving intimacy and sexual satisfaction in couples' relationships (Allgeier & Allgeier, 1995). One way to improve sexual satisfaction and sexual self-esteem is through interventions that specifically target communication between members of the couple (Kelly & Erickson, 2007). Counselors could promote increased attachment security by focusing on negative emotions surrounding abandonment and loss. This can be exponentially effective through group therapy, which provides group members a place to discuss relationships and attachment insecurities (Marmarosh & Tasca, 2013). In addition, researchers have found that family or couples therapy for adult survivors of childhood sexual trauma can be useful treatment modalities for improving attachment security. Also, a strong therapeutic alliance can facilitate a corrective emotional experience in which the therapist can help survivors of childhood sexual trauma by provided a secure base to explore emotions surrounding the trauma (Karakurt & Silver, 2014).

Utilizing an integrated theoretical approach with childhood survivors of sexual trauma can help facilitate conceptualization of clients' thoughts and feelings surrounding the trauma

thereby reducing symptoms such as hypervigilance and anhedonia. For example, Cohen (2008) found that a combination of Emotional Focused Therapy (EFT) and Cognitive Behavioral Therapy (CBT) was effective in working with clients with a history of trauma. Theoretical integration of EFT and CBT focused on thoughts, behaviors and emotions (Cohen, 2008). In addition, feminist therapy can aid clients in building strengths and resilience, reducing PTSD symptomology, and increasing emotional regulation (Cohen, 2008).

As intensity of childhood sexual trauma contributes to subjective well-being, it is important for clinicians to understand how to work with survivors. As stated in the model of restorative well-being, environmental supports and coping can contribute to increased subjective well-being. According to Herman (1992), there are three essential stages to assist clients in overcoming previous sexual trauma. The first stage of this process is for client's to feel safe in their environment. During the second stage of treatment, the focus is on bereavement as the therapist helps the client to mourn the loss of a childhood without trauma. The final phase of Herman's (1992) therapeutic steps includes reconnection to what has been lost. This includes increasing the individual's self-esteem and self-efficacy as well as acknowledging what was lost during the trauma, which is congruent with the model of restorative well-being (Herman, 1992; Lent, 2004).

Strengths of the Present Study

The present study utilized a sound theoretical foundation as well as empirical evidence to support a sound methodological approach. The present study is unique due to its integration of attachment with the model of restorative well-being to analyze adult survivors of childhood trauma in relation to attachment, sexual self-esteem, and subjective well-being. Currently, there is limited research assessing the relationship between subjective well-being and sexual self-

esteem. In addition, there are limited findings incorporating the theories of attachment and the model of restorative well-being. A power analysis was conducted prior to the study as a means of determining adequate sample size and the number of participants in the present study exceeded the number required for adequate power. The scales used to measure attachment security, childhood sexual trauma, sexual self esteem, and subjective well-being were all psychometrically sound and possessed evidence of reliability and validity, thus contributing to internal validity by eliminating threats to internal validity. Additionally, to control for threats to validity such as maturation effects, I presented the scales in a counterbalanced order. The cross-sectional design of the study helped to control for maturity and mortality threats to internal validity.

Limitations of the Present Study

All data were collected at a single Midwestern university. As such, generalizability to other areas of the country or parts of the world are limited. Most participants in the present study were Caucasian, which was representative of the population that the sample was taken from, but may limit generalizability to other ethnic groups. More women than men participated in the study, thus limiting generalizability somewhat to men. Participants completed online surveys for the present study and, as such, the environment in which surveys were completed likely varied across participants. One inherent limitation with the use of self-report measures is that variables were not directly assessed and thus were filtered through the lens of each participant. Finally, there was some attrition in the present study and it's possible that differences exist between those who completed the study and those who discontinued participation.

Directions for Future Research

Future researchers could attempt to study attachment, childhood sexual trauma, sexual self-esteem, and subjective well-being with a more diverse population of participants (e.g., related to gender, ethnicity, geographic location) in order to facilitate greater generalizability. Several questions remain given the results of the current research study. First, based on the model of restorative well-being, coping strategies can be employed to restore feelings of satisfaction and self-esteem in one's life. The current lacks information regarding which coping strategies are most effective in restoring feelings about the self. Conceptually, it would be interesting to explore these same constructs with the addition of multiple different coping strategies as a means of furthering the research and enriching the literature for clinicians working with adult survivors of childhood sexual trauma.

Summary and Conclusions

This study makes a significant contribution to existing literature by providing insight into the relationships between attachment, childhood sexual trauma, sexual self-esteem and subjective well-being within the framework of attachment theory and the model of restorative well being. The current study furthers the existing literature on childhood sexual trauma and subsequent well-being by illuminating the way attachment, childhood sexual trauma and sexual self-esteem contribute to or detract from subjective well-being. The results of the current study will provide researchers and clinicians with a greater depth of understanding regarding the importance of adult attachment and protective factors such as sexual self-esteem in combatting low levels of subjective well-being. For example, the finding that individuals who have experienced stronger rates of childhood sexual trauma experience lower levels of sexual self-esteem and subjective well-being will assist clinicians who work with clients with a history of sexual trauma to better

understand their clients and create targeted treatment strategies. The present study is an important step towards illuminating the relationships between childhood sexual trauma and subjective well-being because it provides further insight into how sexual trauma may impact individuals throughout the lifespan. Clinicians may also wish to consider using the theoretical framework of attachment and restorative well-being to better understand their clients' feelings of worthlessness and lack of comfort in sexual endeavors.

References

- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- Alexander, P. C., Anderson, C. L., Brand, B., Schaeffer, C. M., Grelling, B. Z., & Kretz, L. (1998). Adult attachment and long-term effects in survivors of incest. *Child Abuse and Neglect*, 22, 45–61.
- Alexander, P. C. (2009). Childhood trauma, attachment, and abuse by multiple partners. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1(1), 78–88.
doi:10.1037/a0015254
- Allgeier, A. R. & Allgeier, E. R. (1995). *Sexual Interactions*. Lexington: D.C. Heath and Company.
- Anderson, P. B. & Newton, M. (1997). The Initiating Heterosexual Contact Scale: A factor analysis. *Sexual Abuse: A Journal of Research and Treatment*, 93, 179-186.
- Bailey, H. N., Moran, G., & Pederson, D. R. (2007). Childhood maltreatment, complex trauma symptoms, and unresolved attachment in an at-risk sample of adolescent mothers. *Attachment & Human Development*, 9(2), 139–161. doi:10.1080/14616730701349721
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Barbo, E.J. (2004). The effects of child sexual abuse, child physical abuse, and combined child physical abuse on adult sexual victimization and adult posttraumatic stress disorder (Doctoral dissertation, Northern Illinois University, 2004). *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 64(12-B), 6321.

- Bartholomew, K., & Horowitz, L. (1991). Attachment styles among young adults: A test of a four- category model. *Journal of Personality and Social Psychology*, 61, 226–244.
- Becker-Laussen, E., Sanders, B., & Chinsky, J. M. (1995). Mediation of abusive childhood experiences: Depression, dissociation and negative life outcomes. *American Journal of Orthopsychiatry*, 65(4), 560–573.
- Bernstein, D. P., & Fink, L. (1998). *Childhood Trauma Questionnaire: A retrospective self report manual*. San Antonio, TX: The Psychological Corporation.
- Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., & Zule, W. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse & Neglect*, 27, 169–190. doi:10.1016/S0145-2134(02)00541-0
- Bowlby, J. (1973). *Attachment and loss: Volume 2. Separation: Anxiety and anger*. New York: Basic Books.
- Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss, sadness and depression*. New York: Basic Books.
- Crittenden, P. M. (1997). Truth, error, omission, distortion, and deception: The application of attachment theory to the assessment and treatment of psychological disorder. In S. C. Dollinger & L. F. DiLalla (Eds.), *Assessment and intervention: Issues across the life span* (pp. 35–76). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Cohen, J. N. (2008). Using feminist, emotion-focused, and developmental approaches to enhance cognitive-behavioral therapies for posttraumatic stress disorder related to childhood sexual abuse. *Psychotherapy: Theory, Research, Practice, Training*, 45(2), 227–246. doi:10.1037/0033-3204.45.2.227

- Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125, 276–302.
- Dimitrova, N., Pierrehumbert, B., Glantz, N., Torrissi, R., Heinrichs, M., Halfon, O., & Chouchena, O. (2009). Closeness in relationships as a mediator between sexual abuse in childhood or adolescence and psychopathological outcome in adulthood. *Clinical Psychology and Psychotherapy*, 17, 183-195.
- Fairchild, A. L., & Finney, S. J. (2006). Investigating validity evidence for the Experiences in Close Relationships-Revised Questionnaire. *Educational and Psychological Measurement*, 66(1), 116-135.
- Finkelhor, D., Hotaling, G.T., Lewis, I. A., & Smith, C. (1989). Sexual abuse and its relationship to later sexual satisfaction, marital status, religion, and attitudes. *Journal of Interpersonal Violence*, 4, 379-399.
- Fisher, T. D., Snell, W. E., Jr. (1995). Validation of the Multidimensional Sexuality Questionnaire. Unpublished manuscript, The Ohio University at Mansfield.
- Fraley, R. C., Waller, N. G., & Brennan, K. A. (2000). An item response theory analysis of self-report measures of adult attachment. *Journal of Personality and Social Psychology*, 78(2), 350-365. doi: 10.1037//0022-3514.78.2.350
- Gaynor, P. & Underwood, J. (1995). Conceptualizing and measuring sexual self-esteem. In: P. Shrout & S. Fiske (Eds.). *Personality Research, Methods and Theory: A Festschrift Honoring Donald W. Fiske*. Hillsdale, NJ: Erlbaum.
- Gnilka, P. B., Ashby, J. S., & Noble, C. M. (2013). Adaptive and maladaptive perfectionism as mediators of adult attachment styles and depression, hopelessness and life satisfaction. *Journal of Counseling and Development*, 91, 78–86.

- Harlow, R. E., & Cantor, N. (1996). Still participating after all these years: A study of life task participation in later life. *Journal of Personality and Social Psychology*, 71, 1235–1249.
- Hazan, C., & Shaver, P. R. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52(3), 511-524.
- Hazan, C., & Shaver, P. R. (1994). Attachment as an organizational framework for research on close relationships. *Psychological Inquiry*, 5(1), 1-22.
- Herman, J. (1992). *Trauma and Recovery*, Perseus Book Group: New York.
- Hinnen, C., Sanderman, R., & Sprangers, M. A. G. (2009). Adult attachment as mediator between recollections of childhood and satisfaction with life. *Clinical Psychology & Psychotherapy*, 16(1), 10–21. doi:10.1002/cpp.600
- Hurlbert, D. H. & Apt, C. (1991). Sexual narcissism and the abusive male. *Journal of Sex & Marital Therapy*, 17, 279–292.
- James, R. (2011). Correlates of Sexual Self-Esteem in a Sample of Substance-Abusing Women. *Journal of Psychoactive Drugs*, 43(3), 220–228. doi:10.1080/02791072.2011.605700
- Jiang, X., Huebner, E. S., & Hills, K. J. (2013). Parent attachment and early adolescents' life satisfaction: The mediating effect of hope. *Psychology in the Schools*, 50(4), 340–352. doi:10.1002/pits.21680
- Karakurt, G., & Silver, K. E. (2014). Therapy for childhood sexual abuse survivors using attachment and family systems theory orientations. *The American Journal of Family Therapy*, 42, 79-91
- Kelly, T. C., & Erickson, C. D. (2007). An examination of gender role identity, sexual self-esteem, sexual coercion and sexual victimization in a university sample. *Journal of Sexual Aggression*, 13(3), 235–245. doi:10.1080/13552600701794366

- Kirchmann, H., Nolte, T., Runkewitz, K., Bayerle, L., Becker, S., Blasczyk, V., et al. (2013). Associations between adult attachment characteristics, medical burden, and life satisfaction among older primary care patients. *Psychology and Aging*, 28(4), 1108–1114. doi:10.1037/a0034750
- La Guardia, J. G., Ryan, R. M., Couchman, C. E., & Deci, E. L. (2000). Within-person variation in security of attachment: A self-determination theory perspective on attachment, need fulfillment and well-being. *Journal of Personality and Social Psychology*, 79(3), 367–384. doi:10.1037//0022-3514.79.3367
- Lent, R. W. (2004). Toward a unifying theoretical and practical perspective on well-being and psychosocial adjustment. *Journal of Counseling Psychology*, 51(4), 482-509.
- Leserman, J. (2005). Sexual abuse history: Prevalence, health effects, mediators, and psychological treatment. *Psychosomatic Medicine*, 67(6), 906–915. doi:10.1097/01.psy.0000188405.54425.20
- Liang, B., Williams, L. M., & Siegel, J. A. (2006). Relational Outcomes of Childhood Sexual Trauma in Female Survivors: A Longitudinal Study. *Journal of Interpersonal Violence*, 21(1), 42–57. doi:10.1177/0886260505281603
- Limke, A., Showers, C. J., & Zeigler-Hill, V. (2010). Emotional and sexual maltreatment: Anxious attachment mediates psychological adjustment. *Journal of Social and Clinical Psychology*, 29(3), 347–367.
- Lykken, D., & Tellegen, A. (1996). Happiness is a stochastic phenomenon. *Psychological Science*, 7, 186–189.

- Ma, C. Q., & Huebner, E. S. (2008). Attachment relationships and adolescents' subjective well-being: Some relationships matter more to girls than boys. *Psychology in the Schools*, 45(2), 177–190. doi:10.1002/pits.20288
- Marmarosh, C. L. & Tasca, G. A., (2013). Adult attachment anxiety: Using group therapy to promote change. *Journal of Clinical Psychology: In Session*, 69(11), 1172-1182.
- Mayers, K. S., Heller, D. K., & Heller, J. A. (2003). Damaged sexual self-esteem: A kind of disability. *Sexuality and Disability*, 21(4), 269–282.
- Meehl, P. E. (1975). Hedonic capacity: Some conjectures. *Bulletin of the Menninger Clinic*, 39, 295–307.
- Meier, A. M. (2007). Adolescent first sex and subsequent mental health. *American Journal of Sociology*, 112(6), 1811–1847. doi:0002-9602/2007/11206-0005\$10.00
- Meston, C. M., Lorenz, T. A., & Stephenson, K. R. (2013). Effects of expressive writing on sexual dysfunction, depression, and PTSD in women with a history of childhood sexual abuse: Results from a randomized clinical trial. *The Journal of Sexual Medicine*, 10(9), 2177–2189. doi:10.1111/jsm.12247
- Midei, A. J., Matthews, K. A., Chang, Y.F., & Bromberger, J. T. (2013). Childhood physical abuse is associated with incident metabolic syndrome in mid-life women. *Health Psychology*, 32(2), 121–127. doi:10.1037/a0027891
- Moin, V., Duvdevany, I., & Mazor, D. (2009). Sexual identity, body image and life satisfaction among women with and without physical disability. *Sexuality and Disability*, 27(2), 83–95. doi:10.1007/s11195-009-9112-5

- Moksnes, U. K., & Espnes, G. A. (2013). Self-esteem and life satisfaction in adolescents—gender and age as potential moderators. *Quality of Life Research*, 22(10), 2921–2928. doi:10.1007/s11136-013-0427-4
- Muller, R. T., Sicoli, L. A., & Lemieux, K. E. (2000). Relationship between attachment style and posttraumatic stress symptomatology among adults who report the experience of childhood abuse. *Journal of Traumatic Stress*, 13(2), 321–332.
- Oattes, M. K., & Offman, A. (2007). Global self-esteem and sexual self-esteem as predictors of sexual communication in intimate relationships. *The Canadian Journal of Human Sexuality*, 16(3-4), 1–13.
- Parrot, R. & Hewitt, J. (1978). Increasing self-esteem through participation in a goal-attainment program. *Journal of Clinical Psychology*, 34(4), 955-957.
- Pedhazur, E. J. (1997). *Multiple regression in behavioral research: Explanation and prediction*, Harcourt College Publishers: Orlando, FL.
- Perrone, K.M., & Civileto, C.L. (2004). The impact of life role salience on subjective well-being. *Journal of Employment Counseling*, 41, 105-116.
- Perrone, K. M., Webb, K., & Jackson, V. (2007). Relationships between parental attachment, work, and family roles and life satisfaction. *The Career Development Quarterly*, 55, 237–248.
- Regehr, C., Alaggia, R., Dennis, J., Pitts, A., & Saini, M. (2013). Interventions to reduce distress in adult victims of rape and sexual violence: A systematic review. *Research on Social Work Practice*. doi:10.1177/1049731512474103

- Riggs, S. A., Cusimano, A. M., & Benson, K. M. (2011). Childhood emotional abuse and attachment processes in the dyadic adjustment of dating couples. *Journal of Counseling Psychology, 58*(1), 126–138. doi:10.1037/a0021319
- Robbins, S. B., & Kliever, W. L. (2000). Advances in theory and research on subjective well-being. In S. D. Brown & R. W. Lent (Eds.), *Hand- book of counseling psychology* (pp. 310–345). New York: Wiley.
- Royse, D., Rompf, E. L., & Dhooper, S. S. (1993). Childhood trauma and adult subjective well-being. *The Journal of Applied Social Sciences, 17*(2), 179–189.
- Scher, C. D., Stein, M. B., Asmundson, G. J. G., McCreary, D. R., & Forde, D. R. (2001). The childhood trauma questionnaire in a community sample: Psychometric properties and normative data. *Journal of Traumatic Stress, 14*(4), 843-857.
- Seligson, J. L., Huebner, E. S., & Valois, R. F. (2003). Preliminary validation of the Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS). *Social Indicators Research, 61*, 121-145.
- Simpson, J. A., Rholes, W. S., & Phillips, D. (1996). Conflict in close relationships: An attachment perspective. *Journal of Personality and Social Psychology, 71*(5), 899–914.
- Smith, P. N., Gamble, S. A., Cort, N. A., Ward, E. A., He, H., & Talbot, N. L. (2011). Attachment and alliance n the treatment of depressed, sexually abused women. *Depression and Anxiety, 29*(2), 123–130. doi:10.1002/da.20913
- Snell, W. E., Jr., Fisher, T. D., & Walters, A. S. (1993). The Multidimensional Sexuality Questionnaire: An objective self-report measure of psychological tendencies associated with human sexuality. *Annals of Sex Research, 6*, 27-55.

- Snell, W. E., Fisher, T. D., & Walters, A. S. (2015). The multidimensional sexuality questionnaire: An objective self-report measure of psychological tendencies associated with human sexuality. *Annals of Sex Research*, 6, 27–55.
- Stewart, A. L. (2013). The men's project: A sexual assault prevention program targeting college men. *Psychology of Men and Masculinity*, 1-5 doi: 10.1037/a0033947
- Sugaya, L., Hasin, D. S., Olfson, M., Lin, K. H., Grant, B. F., & Blanco, C. (2012). Child physical abuse and adult mental health: A national study. *Journal of Traumatic Stress*, 25(4), 384–392. doi:10.1002/jts.21719
- Walker, E. A., Gelfand, A., Katon, W. J., Koss, M. P., Von Korff, M., Bernstein, D., & Russo, J. (1999). Adult health status of women with histories of childhood abuse and neglect. *American Journal of Medicine*, 107, 332–339. doi:10.1016/S0002-9343(99)00235-1
- Wasco, S. M. (2003). Conceptualizing the harm done by rape. *Trauma, Violence & Abuse*, 4(4), 309–322. doi:10.1177/1524838003256560
- Wongpakaran, T. & Wongpakaran, N. (2012). A short version of the revised 'Experience of Close Relationships Questionnaire': Investigating non-clinical and clinical samples. *Clinical Practice & Epidemiology in Mental Health*, 8, 36-42.
- World Health Organization. (1948). Charter. Geneva, Switzerland: Author.
- Zeanah, P. & Schwartz, J. (1996). Reliability and validity of the sexual self-esteem inventory for women. *Psychological Assessment*, 3(1), 1-15.
- Zurbriggen, E. L., Gobin, R. L., & Kaehler, L. A. (2012). Trauma, Attachment, and Intimate Relationships. *Journal of Trauma & Dissociation*, 13(2), 127–133. doi:10.1080/15299732.2012.642762

Appendix A

Statement of the Problem

The presence of any trauma can lead to physical and mental health problems among survivors. In the United States, nearly 30% of individuals who seek psychological services are survivors of childhood abuse (Dimitrova et al., 2009). Survivors who have experienced childhood sexual trauma, or any unwanted sexual act prior to the age of 18, are more likely to endorse a myriad of mental health symptomology than are individuals who do not have a history of childhood sexual trauma (Bailey et al., 2007). This symptomology can be consistent with psychological disorders such as PTSD, depression and Bipolar Disorder (Smith et al., 2011). In addition, to vulnerability to these mental health diagnoses, survivors of childhood sexual abuse also have a higher likelihood of revictimization or additional similar trauma in adulthood (Royse et al., 1993). Specifically, these individuals are far more likely to be victimized by romantic partners in adulthood as compared to individuals who do not have a history of sexual trauma (Riggs et al., 2011).

As stated by the World Health Organization (1948), health is comprised of each individual's comprehensive well being. This well-being includes facets of physical, mental and social health. Today, medical models primarily focus on physical functioning and place little emphasis on the mental and social aspects of well-being (Lent, 2004). Subjective well-being includes personality, emotions and biology as well as cognitive, behavioral and social variables. The cognitive, behavioral and social variables are highly intertwined. Individuals contribute to their own well-being by becoming involved in activities that bring enjoyment. These activities may add to the individual's social gain and increase their levels of social support, companionship and overall emotional well-being. Individuals' thoughts and behaviors influence the manner in

which they perceive interpersonal relationships (Lent, 2004). One key component in subjective well-being is attachment.

The study of attachment has been an integral component of psychological research since the 1970s. Attachment theory explains how repetitive interactions between children and their primary caregivers shape the ways in which the child views relationships (Bowlby, 1973). For example, the child may learn to trust if the caregiver consistently tends to their needs when the child cries or asks for help. Studies have shown that individuals who experience trauma, specifically childhood sexual trauma, tend to have insecure levels of attachment (Alexander, 2009; Muller, Sicoli & Lemieux, 2000). Although the original research focused on attachment in infancy, Hazan and Shaver (1987) extended attachment theory to adult relationships (Hazan & Shaver, 1987). The construct of the internal working model explains how beliefs about the self, including self-concept and self-esteem, are influenced by patterns of attachment relationships experienced by the individual in childhood are then internalized and carried forward as a template for future relationships (Hazan & Shaver, 1994). The internal working model is transcendent of time, indicating that the attachment patterns we develop in childhood persist into adulthood (Hazan & Shaver, 1994). Thus childhood sexual trauma likely influences attachment security of the child and the patterns of attachment tend to persist into adulthood unless they are able to address this through effective therapeutic interventions

Sexual self-esteem is the degree to which individuals feel positively about their body and sexual interactions. The construct of sexual self-esteem impacts the way in which people relate to their romantic partners (Kelly & Erickson, 2007). In addition, sexual self-esteem is related to an individuals' level of commitment and attachment to their romantic partners (Zeanah & Schwartz, 1996). Further, research has shown that sexual self-esteem is related to satisfaction

with life (Moin, Duvdevany & Mazor, 2009). In the current study, the constructs of attachment, childhood sexual trauma, sexual self-esteem, and subjective well-being will be assessed as a means of furthering the current literature.

Criterion for Inclusion of Studies in Literature Review

The studies utilized in this literature review were published after Bowlby's (1973) introduction to attachment theory. Literature for the study was gathered through the Academic Search Premier, PsycINFO and PsycARTICLES databases. Research was gathered by focusing on the inclusion of adults who have been victims of childhood sexual trauma and included the following search terms: *childhood trauma*, *childhood sexual trauma*, *sexual self-esteem*, *sexual satisfaction* and *childhood rape*. Specifically, many of these searches included the terms *attachment* and *adult attachment* to focus the research on implications of previous childhood trauma. Studies on sexual self-esteem and subjective well-being were examined when they included one additional construct of interest for the current study (i.e. attachment, childhood trauma, sexual self-esteem and subjective well-being).

Additional requirements for inclusion in this literature review were necessary for creating a cohesive and synthesized review of the literature. First, studies were included only if they analyzed an adult population (ages eighteen and older). Therefore, all studies examining attachment, subjective well-being or sexual self-esteem with children or adolescent participants the age of 17 or younger were omitted. This restriction was implemented because the current study is primarily interested in adult sexual self-esteem and subjective well-being. Additionally, studies that analyzed the effect of these concepts on individual participants were utilized. That is, studies that analyzed couples or families were not analyzed. This study focused on attachment,

history of sexual trauma, sexual self-esteem, and subjective well-being of individuals (rather than couples or families or other groups).

Theory of Well-Being

Introduced by Lent (2004), the theory of well-being is comprised of two sets of variables. Firstly, personality, emotions and biological factors influence our predisposition to having a positive outlook on life. These factors are biologically driven and inherent from birth (Lykken & Tellegen, 1996; Meehl, 1975). Additionally, these constructs can assist in individual's resilience toward negative life situations. According to Diener et al. (1999), "personality is one of the strongest and most consistent predictors of subjective well-being" (p. 279). As discussed by Lent (2004), the second set of variables includes cognitive, behavioral and social constructs. As stated by Lent (2004) these variables represent the "doing versus having sides of personality" (p. 493). This indicates that the cognitive, behavioral and social constructs are impacted by the individual's environment.

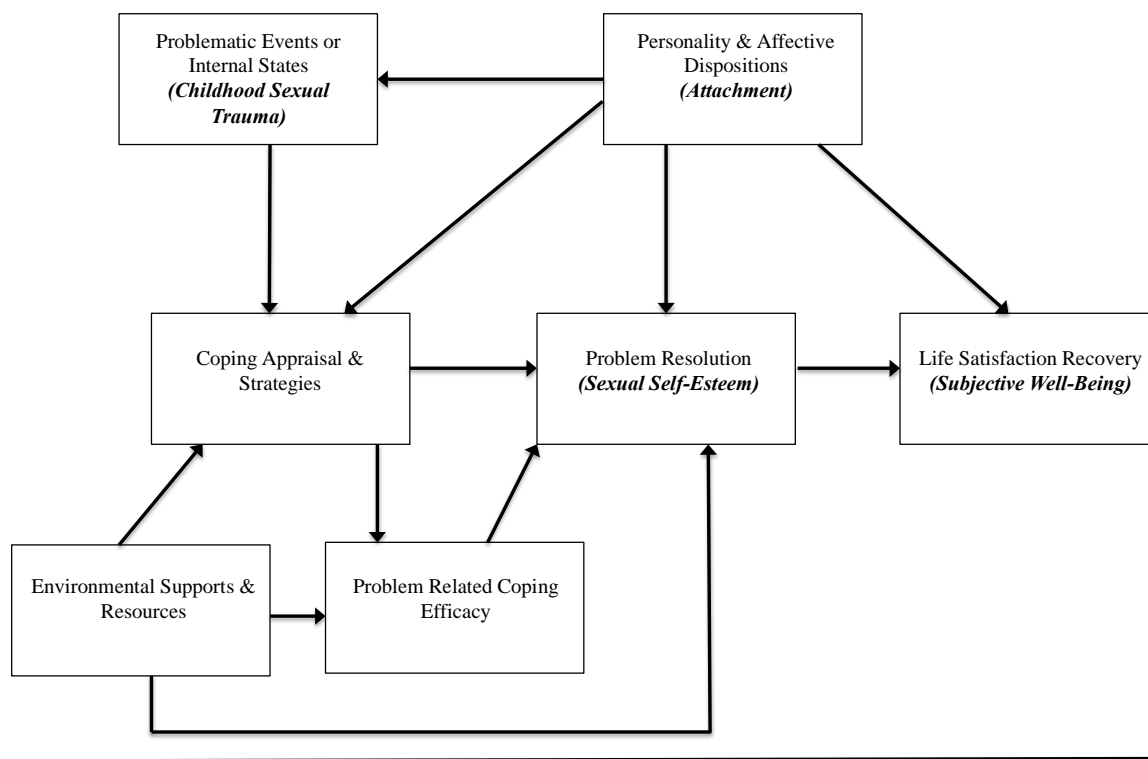
Cognition, according to Lent (2004), is constructed of "personal control beliefs, future outcome expectancies and goal mechanisms" (p. 493). Although these individual aspects of cognition are trait-like in nature, they are subject to environmental mastery. This includes individual characteristics and beliefs about control and ability. In this sense, self-efficacy, or individuals' abilities (or perceived abilities) to complete specific tasks may be influenced by their life situations (Bandura, 1986). Additionally, a belief about an individual's life, whether these beliefs are positive or negative, can impact the individual's capabilities and alter the likelihood of goal attainment (Bandura, 1986; Lent, 2004). As stated previously, our thoughts are impacted through life circumstances; therefore, individuals' thought processes and other aspects of daily living, such as attachment relationships, can impact their perception of well-being.

Behavioral and social constructs of well-being are associated with cognition due to the relationship between process (cognition) and participation (behavior) (Robbins & Kliever, 2000; Lent, 2004). In this method, individuals begin to use goal attainment methods to enact their life objectives. In many cases, individuals will participate in social activities to assist in obtaining their goals. Harlow and Cantor (1996) found that participation in activities that involve interpersonal interaction (e.g., social clubs) increased subjective well-being above all other traits (i.e. previous levels of subjective well-being, extraversion, social support and health). Research has indicated that participation in social activities is beneficial during major life transitions in which an individual's social role may be fluctuating, changing their life's purpose (Harlow & Cantor, 1996). Through these activities, individuals maintain environmental supports and companionship, which increases their likelihood to obtain goals and sustain levels of satisfaction in their lives. For a pictographic explanation see Figure 1.

The Well-Being model assesses the efficacy of specific domains and its overall effectiveness in assessing subjective well-being. According to Lent (2004), a normative model of well-being and a model of restorative well-being are effective in assessing an individual's capability to achieve subjective well-being. For the purpose of this study, the restorative model of well-being was utilized to discuss the relationship between childhood sexual trauma and subjective well-being. In this model, stressful events (such as childhood sexual trauma) can pose challenges to an individual life. Although personality characteristics, such as level of attachment security can impact the manner in which an individual interprets the stressful event, restorative factors such as coping, coping efficacy and problem resolution can have a positive impact on an individual's ability to achieve subjective well-being. In this sense, these restorative factors influence an individual's ability to restore their feelings of satisfaction.

Figure 1

Path Model of Restorative Well-Being Utilizing the constructs of Childhood Sexual Trauma, Attachment, Sexual Self-Esteem and Subjective Well-Being



Attachment Theory

As described by Bowlby (1973) attachment is the social and emotional construct that describes how infants build relationships with their primary caregivers. Children with parents who attend consistently to their needs tend to feel greater security and safety in the relationship. Bowlby (1973) hypothesized that these patterns create frameworks by which attachment behaviors are internalized and interpreted throughout the individual's lifespan. The term *internal working model*, coined by Bowlby, describes how individuals are molded by their caregiver. This *internal working model*, lays the groundwork for how individuals create relationships in later life, indicating that attachment is congruent throughout the lifespan (Hazan & Shaver, 1994).

According to Ainsworth (1978), three different types of attachment style develop during early life stages: secure, anxious/ambivalent and avoidant. At this phase of development, attachment is shaped by the attentive and compassionate nature of the primary caregiver. *Secure* attachment results from consistency of care from parents or caregivers when children are young. Parents of securely attached children utilize both a loving demeanor and appropriate levels of discipline (Ainsworth, 1978). Children display this attachment security by showing little to no distress when given opportunities to explore their world. Children who have *anxious/ambivalent* attachment have caregivers who display inconsistent or mixed responses to their children's needs (Ainsworth, 1978). Children with anxious/ambivalent attachment display signs of anxiety and extreme distress when separated from their caregiver. However, upon their return, the child displays no interest in their parent. Finally, parents who are neglectful to their child create an *avoidant attachment* type. Children with avoidant attachment type have a lack of interest in their primary caregiver. This lack of interest is consistent whether the parent is present or absent from the child (Bowlby, 1973).

According to Hazan and Shaver (1987) there are four central aspects of adult attachment. Firstly, adult relationships need to provide a safe haven to foster healthy adult attachment. Secondly, healthy relationships will provide security for adults to explore their external world. This allows adults to explore other relationships, themselves and their world while still maintaining feelings of security within their romantic relationships. Thirdly, an essential component of adult attachment is proximity seeking (Hazan & Shaver, 1987). Proximity seeking refers to an individual's ability to feel safe and comforted when they are near their romantic partner. Finally, the absence of an individual's romantic partner can result in feelings of discomfort or distress (Hazan & Shaver, 1987). This is similar to the findings on secure infant

attachment, in which children experience separation anxiety when they are not close in proximity to their primary caregiver (Ainsworth, 1978).

Adult attachment models have focused on empirically validating the *internal working model* proposed by Bowlby (1973). Bartholomew and Horowitz (1991) proposed attachment patterns for adults include the following categories: secure, preoccupied, dismissing and fearful attachment. Individuals who have a secure attachment style describe themselves positively. These individuals have a good sense of self-worth as well as an ability to form healthy intimate relationships with others (Bartholomew & Horowitz, 1991). Individuals with preoccupied patterns of attachment have a negative sense of self, which can lead to attempts to seek acceptance and approval from others. Individuals with a dismissing pattern of attachment are often highly independent from others. Individuals with a fearful pattern of attachment attempt to avoid intimacy as a way to protect themselves from rejection or loss (Bartholomew & Horowitz, 1991). The consistency between Bartholomew and Horowitz's (1991) and Bowlby's (1973) attachment styles is the concept of having secure and insecure attachment types. In the attachment types described previously, preoccupied, fearful and dismissing attachment styles are reflective of insecure attachment types. Due to the relationship between childhood and adult attachment, it is evident that assessing adult attachment characteristics will also give insight into childhood attachment patterns.

Theoretical Integration

As discussed previously, the cognition, behavior and social aspects of an individual's life is closely related to their ability to be satisfied (Lent, 2004). In this manner, one can summate that attachment is related closely with these constructs. Further, cognition, behavior and social aspects of the individual are not inherent, but rather impacted by our relationships with others, a

key component of attachment theory (Bowlby, 1973; Lent, 2004). According to Hazan and Shaver (1987), attachment with an individual caregiver is consistent throughout the lifespan, thereby effecting future attachment with romantic partners. These attachments can also be associated with close social relationships. Lent (2004) states that our cognitions and behaviors are closely tied to relationships with others. Social communities, which have common ties, can create strong benefits including emotional supporting for each individual member. Through this individuals will learn that they can feel securely attached to members of their communities.

In the model of restorative well-being, personality and affective dispositions can be easily associated with attachment theory. Although attachment isn't inherent at birth, it is learned during infancy (Bowlby, 1973). In addition, as stated previously, attachment is consistent throughout the lifespan (Hazan & Shaver, 1987). Therefore, attachment can be assumed under the criterion of personality and affective dispositions. As compared to the model proposed by Lent (2004), the current study uses a bilateral correlation between personality and traumatic events. Lent (2004) states that personality characteristics will be a strong indicator of how individuals perceive trauma.

Childhood Sexual Trauma

Childhood trauma of any kind can have a significant deleterious effect on individuals' well-being that, if not treated through therapy, can continue as they grow older. This is particularly true regarding the relationship between childhood maltreatment and interpersonal functioning (Bailey, Moran & Pederson, 2007). In an article assessing 62 women who became mothers during adolescence over a two-year period, results indicated that individuals who experienced sexual trauma during childhood also experienced emotional abuse or additional

traumatic experiences. This is consistent with the previously described research on revictimization (Royse et al., 1993).

Childhood sexual trauma, for the purpose of this study, is defined as any unwanted sexual act occurring prior to the age of 18. Sexual trauma is defined as: “any act perpetrated on a child by a significantly older person with the intent to stimulate the child sexually and to satisfy the aggressor’s sexual impulses” (Barbo, 2004, p. 12). In addition to research on childhood experiences of sexual trauma, research has found that consensual sexual activity in early adolescence can increase the likelihood that an individual will experience depression and subsequent mental health issues (Meier, 2007). This indicates that any sexual experiences prior to a certain age can be harmful for the child. A sample of 14,736 adolescents was analyzed as part of a greater health study utilizing measures to analyze depression, self-esteem as well as the adolescents’ first sexual experience. Research found that first sexual experiences were reported to occur between the ages of 13 and 17 years across populations with a variety of demographic characteristics. Researchers in this study found that sex during adolescence can lead to depression and lowered self-esteem when the individual’s relationship is dissolved or if that relationship lacks emotional commitment (Meier, 2007). This supports the notion that any kind of childhood sexual experiences can be problematic, thereby making childhood sexual trauma that much more dangerous.

Mental health symptoms are exacerbated when sexual trauma is involved. Individuals with childhood sexual abuse histories are more likely than those without a history of childhood sexual abuse likely to be diagnosed with depression, PTSD and Bipolar Disorder (Smith, Gamble, Cort, Ward, He & Talbott, 2011). Smith and colleagues (2011) surveyed 70 women between the ages of 19 and 57 who met criteria for depression from the DSM IV-TR and

reported history of childhood sexual abuse. Participants were asked to complete the Beck Depression Inventory, The Working Alliance Inventory and the Experiences in Close Relationships Scale. Results from this study indicated that individuals who had secure relationships reported less depressive symptomology than their non-securely attached counterparts.

It is difficult to categorize traumatic experiences into specific diagnoses. Through limiting the research to specific diagnoses, researchers tend to rule out individual differences that may be due to societal reactions and victim-blaming behaviors from peer and family groups (Wasco, 2003). As described by Wasco (2003) victim-blaming behaviors can lead to re-traumatization and a wide array of distress symptoms.

Sexual Self-Esteem

Sexual self-esteem is the “tendency to value, versus devalue, one’s own sexuality, thereby being able to approach rather than avoid sexual experiences both with self and others” (Gaynor & Underwood, 1995). According to Kelly and Erickson (2007), problems with this concept include its broad definition. The definition described previously can lead researchers to be confused regarding the differences between sexual self-esteem and general self-esteem (Kelly & Erickson, 2007). Due to this, Zeanah and Schwartz (1996) created a new definition for the paradigm. “Sexual self-esteem is a manner in which individuals understand their feelings, thoughts and behaviors regarding sex and sexuality” (Zeanah & Schwartz, 1996). This definition narrows the scope of sexual self-esteem by focusing on individuals’ perceptions of themselves as well as their sexual experiences. The definition created by Gaynor and Underwood (1995), focuses solely on one’s ability to partake in sex, while the Zeanah and Schwartz (1996) definition allows for a broader understanding of sexuality. Sexual self-esteem is highly impacted

by previous sexual encounters. James (2011) argued that sexual self-esteem is only increased through positive and committed romantic and sexual relationships. According to Mayers, Heller and Heller (2003) damaged sexual self-esteem impacts an individual's "self-view, satisfaction with life, capability to experience pleasure, willingness to interact with others and ability to develop intimate relationship may be limited" (p. 269). This can impact an individual's ability to feel satisfied with any social or sexual aspect of their life. Additionally, individuals who have conservative views (e.g., abstinence until marriage), may have negative views of themselves, including disgust when they have uninhibited sexual interactions (Mayers et al., 2003). Feelings of shame and embarrassment as well as the onset of sexually transmitted diseases may engender self-loathing and decreased self-worth (Mayers et al., 2003).

High levels of sexual self-esteem are associated with healthy relationships, good interpersonal communication skills and little need to dominate the relationship (Allgeier & Allgeier, 1995; Hurlbert & Apt, 1991). Research has shown that sexual self-esteem is higher in the male population as compared to the female population (Kelly & Erickson, 2007). Kelly and Erickson (2007) surveyed 84 male and female participants between the ages of 18 and 37 years to assess the relationship between social desirability, gender role identity and sexual self-esteem. The researchers found that men with more traditional attitudes were more likely to engage in aggressive sexual behaviors than their female counterparts with traditional attitudes. In addition, it was found that male participants reported higher sexual self-esteem as compared to female participants.

Mayers et al. (2003) reported on five case studies of individuals who had experienced with sexual trauma. According to Mayers et al. (2003), individuals can alter the way they feel about themselves as sexual beings through positive communication with their partner,

reassurance by their partner and others, and through seeking psychological treatment. Individuals who perceive their bodies or general sexual interaction in a negative manner are likely to experience decreased sexual self-esteem. Sexual self-esteem is also influenced by interactions with others. The use of language, either spoken or interpreted, influences the ways in which we understand ourselves (Mayers et al., 2003). This indicates that our relationships with others impact the narratives we create about our sexual experiences, which in turn may have deleterious consequences for sexual self-esteem, especially for individuals who are survivors of childhood sexual trauma.

Subjective Well-Being

Subjective well-being is defined as a “global feeling of contentment, fulfillment, or happiness with life in general” (Perrone & Civiletto, 2004 p. 107). Clinicians and researchers alike have been interested in the concept of subjective well-being for a number of years. Subjective well-being provides an understanding for how an satisfied individuals are with their lives. Research has shown that individuals with low sexual satisfaction have low subjective well-being (Moin, Duvdevany, Mazor, 2009). A study assessing 134 women, 70 with and 64 without physical disability (specifically spinal cord and polio injuries) compared sexual self-esteem and subjective well-being. The researchers assessed the participants’ demographic information, the sexuality scale, body image scale, and the quality of life questionnaire. Results from this study indicated that women with physical disabilities had significantly more negative body image, lower sexual self-esteem, lower sexual satisfaction and lower subjective well-being than their non-disabled counterparts. Results from this study indicate that our perceptions of ourselves impact the manner in which we feel about ourselves as sexual beings as well as how we perceive our overall well-being (Moin et al, 2009).

Multiple aspects of an individual's life, including attachment, affect subjective well-being (Hinnen, Sanderman & Sprangers, 2009; Gnilka, Ashby & Noble, 2013). This relationship can be significant, especially in early adolescence (Ma & Hueber, 2008). A study conducted by Ma and Hueber (2008), assessed 1,201 middle school children ranging in age from 10 to 16 years. Participants completed a survey to assess family context, parental rearing behavior, childhood adversities, adult attachment style and life satisfaction. Results from this study indicate parental attachment and peer attachment contribute to global feelings of subjective well-being (Ma & Hueber, 2008). Researchers stated that these results are exceedingly important as adolescence marks rapid changes in attachment relationships as adolescents move away from the relationships with their parents and form closer bonds to peers. Indicating that no matter the level of independence, relationships with others contribute to subjective well-being.

When individuals are faced with childhood trauma, these individuals may form insecure attachments to the people around them, which influences that individual's global sense of happiness and satisfaction with life (Royse, Rompf & Dhooper, 1993). Research has shown that individuals who have experienced childhood trauma are likely to carry those feelings into adulthood, influencing the manner in which they feel about their life (Royse, Rompf & Dhooper, 1991). Multiple facets of individuals' lives, including the way they feel about themselves sexually, impact subjective well-being. As stated previously, it is also apparent that our relationships with others influence our perception of life, indicating that attachment also influences subjective well-being.

Childhood Sexual Trauma and Attachment

Individuals who have unresolved attachment issues from childhood are 90% more likely than those with secure attachment to report multiple victimizations in adulthood (Alexander,

2009). Further, it has been found that individuals who report sexual maltreatment during childhood are likely to report anxious or avoidant attachment styles (Limke, Showers & Zeigler-Hill, 2010). Due to the relationship between secure attachment and overall subjective well-being, individuals who experience childhood sexual trauma are more likely to have poor subjective well-being (Zurbriggen, Gobin & Kahler, 2012).

Similarly, childhood sexual trauma is often associated with passivity and hostile conflicts in both childhood and current interpersonal relationships (Alexander, 2009). It has been found that when conflicts arise, individuals with insecure, particularly avoidant attachment, view their partners as less supportive, post conflict (Simpson, Rholes & Phillips, 1996). These researchers analyzed 123 dating heterosexual couples, finding that individuals with insecure attachment styles have higher levels of anxiety, stress, anger and hostility when discussing problems with their significant others. This indicates that our relationships in the past impact the manner in which we relate to romantic partners in the future.

Specifically, researchers analyzed 93 women who were seeking services for interpersonal violence at different facilities in the Mid-Atlantic area (Alexander, 2009). Participants in this study answered questions to measure current relationship violence, history of trauma in childhood and/or adulthood, adult attachment and affect regulation. Results from this study indicate that experience of childhood sexual trauma contribute to revictimization and affect deregulation. In addition, presence of childhood sexual trauma appears to have an association with insecure attachment to caregivers (Alexander, 2009).

It has been found that individuals who use avoidant strategies do so to protect themselves from having psychological damage. It is important to note that exaggerated avoidant strategies can increase the symptoms associated with complex trauma (Bailey et al., 2007). Anxious and

avoidant attachment styles have been consistently linked to poor adjustment and greater levels of mental illness than other attachment styles (Limke, Showers & Zeigler-Hill, 2010). In this study 1,457 undergraduate students were analyzed to understand emotional maltreatment and insecure attachment. Researchers found that individuals who had experienced emotional and sexual trauma reported both anxious and avoidant insecure attachment styles (Limke et al., 2010).

As described previously, childhood sexual trauma is associated with mental health issues, particularly posttraumatic stress disorder (PTSD) symptoms. Muller, Sicoli and Lemieux (2000) assert that a negative view of the self is indicative of an individual having PTSD symptoms. Individuals with insecure attachment styles often maintain this negative view of themselves particularly due to receiving negative feedback in their relationships (Muller et al., 2000). Muller et al.'s (2000) study assessed 411 participants with a history of physical and/or sexual abuse. Researchers assessed childhood victimization, (e.g. positive parenting practices, psychological abuse, physical abuse, domestic violence and sexual abuse), adult attachment and PTSD symptoms. Results indicated that $\frac{3}{4}$ of participants had insecure attachment which is consistent with previous research findings (Alexander et al., 1998). In addition, it was found that negative views of self and relationships attribute to PTSD symptomology. As described by attachment theory, insecure attachment styles disrupt an individual's schema of themselves and cause stunting in psychosocial and emotional development (Bowlby, 1980; Crittenden, 1997). This implies that although individuals may have securely attached relationships in adulthood, they could have problems or concerns about their overall abilities and self-worth (Limke et al., 2010).

Childhood Sexual Trauma and Sexual Self-Esteem

As described previously, high levels of sexual self-esteem are associated with healthy sexual relationships (Kelly & Erickson, 2007). Researchers have found that childhood abuse;

specifically sexual abuse, can have long lasting effects on the sexual self-esteem of survivors (Allgeier & Allgeier, 1995; Anderson & Newton, 1997).

According to Mayers et al. (2003), sexual self-esteem can be predicted by sexual trauma during both childhood and adulthood. Sexual trauma can give individuals a negative view of themselves as sexual beings. The use of sexual threats or insults during the perpetration of sexual assault can inhibit an individual's feelings toward sexual acts in the future (Mayers et al., 2003). Due to previous sexual trauma, survivors can be more vulnerable to later sexual damage. Sexual insults perpetrated may be internalized, reducing the individual's sexual self-esteem. According to Allgeier and Allgeier (1995), sexual self-esteem is associated with issues related to previous sexual trauma. It is evident through these findings that sexual self-esteem will affect the way in which individuals feel about themselves, which could in turn influence overall subjective well-being.

Attachment and Sexual Self-Esteem

Sexual self-esteem is at its highest when individuals are in healthy relationships with positive and open communication (Oattes & Offman, 2007). In their research Oattes and Offman (2007) analyzed 74 heterosexual participants, 27 of whom were male and 47 were female. Results from this study indicated that sexual self-esteem and sexual satisfaction is highest when and individual feels emotionally connected to their romantic partner, so that open and honest communication is apparent. Well-developed communication skills and confidence in relationships can increase general self-esteem (Kelly & Erickson, 2007). Although there is limited research directly relating the constructs of attachment and sexual self-esteem, the connection between sexual self-esteem and healthy relationships appears to be a logical one. Securely attached individuals have a strong level of trust in their partner. Strong levels of

communication characterize this trust and ability to express one's needs to his or her partner (Hazan & Shaver, 1987). This suggests that a secure attachment would lead to higher levels of sexual self-esteem.

Damages to sexual self-esteem, according to Mayers et al. (2003), can cause severe distress and decreased mental health. Sexual insults are often utilized to criticize individuals into feeling negatively about their body, even if these insults are deemed incorrect. Mayers and colleagues (2003) studied caregivers employed at a residential care facility for older adults and found that caregivers reported sexual insults from residents were among the most distressing. As stated by Mayers et al. "even a baseless sexual insult from a non-credible source can be devastating to its recipient, and often more traumatic than a valid and credible but non-sexual insult" (p. 272). Sexual self-esteem is highly associated with the relationships we have with others, whether they are caregivers or romantic partners (Oattes & Offman, 2007). Attachment patterns or interpersonal relationships can also influence overall well-being in addition to sexual self-esteem.

Attachment and Subjective Well-Being

Previous research has indicated that secure attachment is positively related to high levels of subjective well-being. La Guardia, Ryan, Couchman and Deci (2000) conducted three research studies investigating the relationship between attachment and happiness. The first of these studies analyzed 138 undergraduate participants as a means of understanding the relationship between self-esteem, attachment and well-being. The second research study refined the initial study, analyzing 152 undergraduate students at the University of Rochester. The researchers examined the constructs of attachment, need satisfaction and well-being and found that attachment security is associated with higher levels of overall well-being. According to

findings from an empirical study by La Guardia et al. (2000), perception of one relationship may not significantly influence attachment. It is perception of multiple relationships that affect way in which we perceive our external world, not the perception of individual relationships (La Guardia et al., 2000). As compared to this, the third study refined these findings and analyzed the relationship between attachment in romantic and parental relationships had an impact on relationship satisfaction. Researchers surveyed 160 participants and found that with-in relationship satisfaction has no impact on overall attachment style. The final study This leads one to understand that secure attachment style in relationships is associated with subjective well-being rather than attachment in one relationship.

Additional studies have corroborated these findings. For example, Jiang, Huebner and Hills (2013) surveyed 1,201 middle school children in the southeastern sector of the United States regarding attachment, hope, and subjective well-being. Their findings indicated that participants who reported secure parent child attachments had higher levels of subjective well-being than individuals who reported insecure parent child attachments. According to Perrone, Webb and Jackson (2007), parental attachment effects individual's life satisfaction in adulthood. Participants who were securely attached reported feeling love and support as well as valuing the skills or morals taught in their childhood. These findings are consistent with those of Kirchmann and colleagues (2013) who studied 81 individuals between the age of 69 and 73 regarding attachment style, medical burden, coping deficits and losses in later life as well as overall levels of life satisfaction. Findings from this study indicated that secure attachment moderates problems such as medical burdens when assessing life satisfaction and found that attachment was associated with subjective well-being across various demographic factors such as age, SES, coping strategies and medical problems (Kirchmann et al., 2013).

Childhood Sexual Trauma and Subjective Well-Being

Childhood abuse, whether sexual, physical or emotional is a violation of trust and boundaries (Finkelhor & Brown, 1985). As stated previously, the experience of abuse can have deleterious effects on well-being in adulthood (Bailey et al., 2007). According to Becker-Lausen, Sanders and Chinsky (1995), childhood trauma is associated with negative perceptions of life for participants of both genders. In the study, 301 undergraduate students were surveyed regarding depression, dissociation, interpersonal difficulties, revictimization, stressful life experiences, and psychological maltreatment. Results indicated that survivors of childhood sexual abuse are more likely to be report both dissociative and depressive symptoms than their non-abused counterparts.

In addition, it was found that the presence of childhood maltreatment causes significant problems in later life including depression, dissociations, revictimization and problems maintaining interpersonal relationships. This includes both romantic relationships and non-romantic relationships. A meta-analysis of the mediating effects of psychological treatment for survivors of sexual trauma (Leserman, 2005) found that poor health status (behavioral, physical, psychological and neuroanatomical) decreased individuals' perceptions of well-being. As described by Leserman (2005), abuse history results in a greater likelihood of headaches, gastrointestinal difficulties, gynecological problems, and prevalence of panic attacks. An additional study analyzing 437 adult participants found that a warm and harmonious parental support provided secure levels of attachment. In addition, individuals who experienced childhood sexual trauma had higher levels of insecure attachment (Hinnen, Sanderman & Sprangers, 2009).

Sexual Self-Esteem and Subjective Well-Being

Currently, minimal research has been conducted analyzing the relationship between sexual self-esteem and subjective well-being. According to Moin et al. (2009), an individual's sexual identity is comprised of sexual self-esteem, sexual preoccupation and sexual satisfaction. In a study analyzing the relationship between sexual satisfaction, sexual self-esteem and subjective well-being, a positive correlation was found between the three constructs (Moin et al., 2009). Additional components of subjective well-being, including sexual satisfaction and relationship satisfaction are influenced by the way individuals feel about themselves sexually. This indicates that an individual's subjective well-being will be associated with his or her sexual self-esteem (Gnilka, Ashby & Noble, 2013). According to Oattes and Offman (2003), an individual's ability to communicate with his or her partner is associated with attachment style. This ability to communicate with one's partner is the cornerstone of building sexual self-esteem. Research has shown that there is a positive relationship between sexual self-esteem and sexual satisfaction (Moin et al., 2009).

Conclusion

The research has demonstrated a relationship between previous sexual trauma and insecure levels of attachment. As described previously, research has shown that sexual self-esteem is related to attachment and childhood sexual trauma (Kelly & Erickson, 2007; Moin, 2009). The presence of childhood trauma has been shown to effect individuals throughout the lifespan, especially when they do not have positive attachment relationships to compensate for this trauma. Research indicates that the presence of childhood insecure attachment will increase the likelihood that the individual will be insecurely attached in adulthood (Hazan & Shaver, 1987). Consequently, negative adult attachment and presence of childhood sexual trauma

increases the likelihood that an individual will have negative sexual self-esteem (Oattes & Offman, 2007; Allgeier & Allgeier, 1995; Anderson & Newton, 1997) and lower subjective well-being (Kirchman et al., 2013; La Guardia et al., 2000; Moin et al., 2009; Leserman, 2005; Becker-Laussen, 1995).

Through analysis of the literature, it is evident that there are several points that could be further analyzed to understand the interactions between attachment, sexual trauma, sexual self-esteem and subjective well-being. This analysis will allow researchers and clinicians to understand how to increase a client's subjective well-being when they have experienced a previous trauma. This dissertation research will be employed to better understand how attachment, childhood sexual trauma, sexual self-esteem, and subjective well-being are interrelated.

Results from this study will help inform researchers and clinicians regarding how childhood sexual trauma can affect relationships and well-being in adulthood. Current research has allowed academics to recognize that adult attachment and childhood trauma are related and thereby can affect the way individuals feel about themselves. According to research, sexual self-esteem can be increased through positive communication regarding sexual needs and sexual identity as well as securely attached relationships (Oattes & Offman, 2007). This indicates that individuals who have a history of childhood trauma as well as insecure attachment have the ability to increase their subjective well-being through their sexual self-esteem.

Appendix B

Informed Consent

Study Title Attachment, Self-Esteem and Subjective Well-Being Among Survivors of Childhood Sexual Trauma

Study Purpose and Rationale

The purpose of this research project is to examine the relationship between attachment, sexual self-esteem and subjective well-being among survivors of sexual assault. In addition, researchers will be examining and comparing levels of subjective well-being between survivors and non-survivors.

Inclusion/Exclusion Criteria

To be eligible to participate in this study, you must be a Ball State University student. Participants must be between the ages of 18 and 35.

Participation Procedures and Duration

For this project, you will be asked to complete a series of questions. It will take approximately 30 minutes to complete the questionnaire.

Data Confidentiality or Anonymity

Responses to the questionnaire will be anonymous.

Storage of Data

The data will also be entered into a software program and stored on the researcher's password-protected computer for three years and then deleted. Only the primary investigator and faculty advisor will have access to the data. Data will be destroyed after the study has been completed, approximately 3 years, after this time, the data will be wiped from the hard drive of the computer.

Risks or Discomforts

The only anticipated risk from participating in this study is that you may not feel comfortable answering some of the questions. This survey may cause survivors to feel triggered, therefore, you may choose not to answer any question that makes you uncomfortable and you may quit the study at any time.

Who to Contact Should You Experience Any Negative Effects from Participating in this Study

Should you experience any feelings of anxiety, there are counseling services available to you through the Ball State University Counseling Center at 765-285-1736. In addition the Office of Victim Services is available to discuss any questions you may have about past and/or current assault. Please call OVS at 765-286-7844.

Benefits

One benefit you may gain from participating in this study may be a better understanding of your own childhood experiences and how that may impact your later life sexual self-esteem and subjective well-being.

Compensation

Students enrolled in CPSY 110, 230, 360, 400, 420, 470 and 490 can receive 1 hour of research credit toward their CPSY requirement. Students who wish to receive this credit will be asked to email the primary researcher to confirm that they have completed the study. The researcher will then email the individuals CPSY instructor to inform them on study completion so they may receive their credit.

Voluntary Participation

Your participation in this study is completely voluntary and you are free to withdraw your permission at anytime for any reason without penalty or prejudice from the investigator. Please feel free to ask any questions of the investigator before signing this form and at any time during the study.

IRB Contact Information

For one's rights as a research subject, you may contact the following: For questions about your rights as a research subject, please contact the Director, Office of Research Integrity, Ball State University, Muncie, IN 47306, (765) 285-5070 or at irb@bsu.edu.

Study Title Attachment, Self-Esteem and Subjective Well-Being Among Survivors of Childhood Sexual Trauma

Consent

By clicking the consent button below, I acknowledge that I agree to participate in this research project entitled, "Attachment, Self-Esteem and Subjective Well-Being Among Survivors of Childhood Sexual Trauma." I have read the description of this project and give my consent to participate.

To the best of my knowledge, I meet the inclusion/exclusion criteria for participation in this study.

Researcher Contact Information

Principal Investigators:

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Ball State University

Muncie, IN 47306

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Appendix C Recruitment Email

Dear Student,

You are invited to participate in a dissertation study investigating the effects of childhood sexual trauma on later life well-being and self-esteem. Individuals who have and have not experienced childhood sexual trauma are welcome to participate. If you choose to participate in this study you will be asked to respond to questions about your attachment style, history of childhood trauma, perceptions on sexuality, overall well-being and demographic information (e.g., race/ethnicity, age, etc.). While some information may be considered sensitive, your honest response to all questions is requested. In order to participate you must be at least 18 years old. Your participation in this study is expected to take 30 to 40 minutes. Participants can choose to receive research participation toward the CPSY requirement OR have a \$1 donation made The Rape, Abuse and Incest National Network (RAINN). The survey will be open from October 2014 to March 2015.

The online survey can be found at:

https://bsu.qualtrics.com/SE/?SID=SV_2ofB8EVIKO2ki57

By completing this survey you will help to further understanding of the effects of childhood sexual trauma on later life relationships, which will allow counselors to be better informed when working with survivors.

Sincerely,

Emily L. Barnum, M.A.

Principal Investigator

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Kristin M. Perrone-McGovern, PhD.

Faculty Advisor

Counseling Psychology & Guidance Services

Ball State University

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Appendix D IRB Approval



Office of Research Integrity
Institutional Review Board (IRB)
2000 University Avenue
Muncie, IN 47306-0155
Phone: 765-285-5070

DATE: October 21, 2014

TO: Emily Barnum

FROM: Ball State University IRB

RE: IRB protocol # 663511-1

TITLE: ATTACHMENT, SELF-ESTEEM AND SUBJECTIVE WELL-BEING, AMONG SURVIVORS OF CHILDHOOD SEXUAL TRAUMA

SUBMISSION TYPE: New Project

ACTION: APPROVED

DECISION DATE: October 21, 2014

EXPIRATION DATE: October 20, 2015

REVIEW TYPE: **Expedited:** This protocol had been determined by the board to meet the definition of minimal risk.

The Institutional Review Board has approved your New Project for the above protocol, effective October 21, 2014 through October 20, 2015. All research under this protocol must be conducted in accordance with the approved submission and in accordance with the principles of the Belmont Report.

Review Type:

	Category 1: Clinical studies of drugs and medical devices
	Category 2: Collection of blood samples by Finger stick, Heel stick, Ear stick, or Venipuncture
	Category 3: Prospective collection of biological specimens for research purposes by noninvasive means
	Category 4: Collection of data through Non-Invasive Procedures Routinely Employed in Clinical Practice, excluding procedures involving Material (Data, Documents, Records, or Specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis)
	Category 5: Research involving materials that have been collected or will be collected solely for non-research purposes.
	Category 6: Collection of Data from Voice, Video, Digital, or Image Recordings Made for Research Purposes

X	Category 7: Research on Individual or Group Characteristics or Behavior or Research Employing Survey, Interview Oral History, Focus Group, Program Evaluation, Human Factors, Evaluation, or Quality Assurance Methodologies
	Category 8: Continuing review of research previously approved by the convened IRB
	Category 9: Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories 2-8 do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and not additional risks have been identified.

Editorial Notes:

1. Approved

As a reminder, it is the responsibility of the P.I. and/or faculty sponsor to inform the IRB in a timely manner:

- when the project is completed,
- if the project is to be continued beyond the approved end date,
- if the project is to be modified,
- if the project encounters problems, or
- if the project is discontinued.

Any of the above notifications must be addressed in writing and submitted electronically to the IRB (<http://www.bsu.edu/irb>). Please reference the IRB protocol number given above in any communication to the IRB regarding this project. Be sure to allow sufficient time for review and approval of requests for modification or continuation. If you have questions, please contact John Mulcahy at (765) 285-5106 or jmulcahy@bsu.edu.

In the case of an adverse event and/or unanticipated problem, you will need to submit written documentation of the event to IRBNet under this protocol number and you will need to directly notify the Office of Research Integrity (<http://www.bsu.edu/irb>) **within 5 business days**. If you have questions, please contact (ORI Staff).

Please note that all research records must be retained for a minimum of three years after the completion of the project or as required under Federal and/or State regulations (ex. HIPAA, FERPA, etc.). Additional requirements may apply.

Appendix E

The Experiences in Close Relationships-Revised Questionnaire (ECR-R)

Instructions: The statements below concern how you feel in emotionally intimate relationships. We are interested in how you generally experience relationships, not just what is happening in a current relationship. Respond to each statement by clicking a circle to indicate how much you agree or disagree with the statement.

The following 7-point Likert type scale is used for and listed after each item:

Strongly Agree (1) O O O O O O O Strongly Disagree (7)

1. I'm afraid I will lose my partner's love.
2. I often worry that my partner will not want to stay with me.
3. I often worry that my partner doesn't really love me.
4. I worry that romantic partners won't care about me as much as I care about them
5. I often wish that my partner's feelings for me were as strong as my feelings for him or her.
6. I worry a lot about my relationships.
7. When my partner is out of sight, I worry that he or she might become interested in someone else.
8. When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.
9. I rarely worry about my partner leaving me. (R)
10. My romantic partner makes me doubt myself.
11. I do not often worry about being abandoned. (R)
12. I find that my partner(s) don't want to get as close as I would like.
13. Sometimes romantic partners change their feelings about me for no apparent reason.
14. My desire to be very close sometimes scares people away.
15. I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.
16. It makes me mad that I don't get the affection and support I need from my partner.
17. I worry that I won't measure up to other people.
18. My partner only seems to notice me when I'm angry.
19. I prefer not to show a partner how I feel deep down.
20. I feel comfortable sharing my private thoughts and feelings with my partner. (R)
21. I find it difficult to allow myself to depend on romantic partners.
22. I am very comfortable being close to romantic partners. (R)
23. I don't feel comfortable opening up to romantic partners.
24. I prefer not to be too close to romantic partners.
25. I get uncomfortable when a romantic partner wants to be very close.
26. I find it relatively easy to get close to my partner. (R)
27. It's not difficult for me to get close to my partner. (R)
28. I usually discuss my problems and concerns with my partner. (R)

- 29. It helps to turn to my romantic partner in times of need. (R)
- 30. I tell my partner just about everything. (R)
- 31. I talk things over with my partner. (R)
- 32. I am nervous when partners get too close to me.
- 33. I feel comfortable depending on romantic partners. (R)
- 34. I find it easy to depend on romantic partners. (R)
- 35. It's easy for me to be affectionate with my partner.
- 36. My partner really understands me and my needs. (R)

Note. (R) Indicates a reverse-scored item. Items 1-18 comprise the anxiety subscale. Lower scores on this subscale indicate higher attachment anxiety. Items 19-36 comprise the avoidance subscale. Lower scores on this subscale indicate higher attachment avoidance. Therefore, lower scores on the total scale indicate greater attachment insecurity and higher scores on the total scale indicate greater attachment security.

Appendix F

The Brief Multidimensional Students' Life Satisfaction Scale

Please respond to each item with one of the following options by clicking the appropriate circle:

Items are rated on a 7-point scale, with responses ranging from Terrible to Delighted.

1	2	3	4	5	6	7
Terrible	Unhappy	Mostly Dissatisfied	Mixed(equally satisfied and dissatisfied)	Mostly satisfied	Pleased	Delighted

1. I would describe my satisfaction with my family life as _____
2. I would describe my satisfaction with my friendships as _____
3. I would describe my satisfaction with my school experience as _____
4. I would describe my satisfaction with myself as _____
5. I would describe my satisfaction with where I live as _____
6. I would describe my satisfaction with my overall life as _____

Appendix G

Multidimensional Sexuality Questionnaire

Instructions: Listed below are several statements that concern the topic of sexual relationships. Please read each item carefully and decide to what extent it is characteristic of you. Some of the items refer to a specific sexual relationship. Whenever possible, answer the questions with your current partner in mind. If you are not currently dating anyone, answer the questions with your most recent partner in mind. If you have never had a sexual relationship, answer in terms of what you think your responses would most likely be. Then, for each statement fill in the response on the answer sheet that indicates how much it applies to you by using the following scale:

1	2	3	4	5
Not at all	Slightly	Somewhat	Moderately	Very
characteristic	characteristic	characteristic	characteristic	characteristic
of me.	of me.	of me	of me	of me

1. I am confident about myself as a sexual partner.
2. I think about sex all the time.
3. My sexuality is something that I am largely responsible for.
4. I am very aware of my sexual feelings.
5. I'm very motivated to be sexually active.
6. I feel anxious when I think about the sexual aspects of my life.
7. I'm very assertive about the sexual aspects of my life.
8. I am depressed about the sexual aspects of my life.
9. The sexual aspects of my life are determined mostly by chance happenings.
10. I sometimes wonder what others think of the sexual aspects of my life.
11. I am somewhat afraid of becoming sexually involved with another person.
12. I am very satisfied with the way my sexual needs are currently being met.
13. I am a pretty good sexual partner.
14. I think about sex more than anything else.
15. The sexual aspects of my life are determined in large part by my own behavior.
16. I'm very aware of my sexual motivations.
17. I'm strongly motivated to devote time and effort to sex.
18. I'm worried about the sexual aspects of my life.
19. I'm not very direct about voicing my sexual preferences. (R)
20. I am disappointed about the quality of my sex life.
21. Most things that affect the sexual aspects of my life happen to me by accident.
22. I'm very concerned with how others evaluate the sexual aspects of my life.
23. I sometimes have a fear of sexual relationships.

24. I am very satisfied with my sexual relationship.
25. I am better at sex than most other people.
26. I tend to be preoccupied with sex.
27. I am in control of the sexual aspects of my life.
28. I tend to think about my sexual feelings.
29. I have a strong desire to be sexually active.
30. Thinking about the sexual aspects of my life leaves me with an uneasy feeling.
31. I am somewhat passive about expressing my sexual desires. (R)
32. I feel discouraged about my sex life.
33. Luck plays a big part in influencing the sexual aspects of my life.
34. I'm very aware of what others think of the sexual aspects of my life.
35. I sometimes am fearful of sexual activity.
36. My sexual relationship meets my original expectations.
37. I would rate myself pretty favorably as a sexual partner.
38. I'm constantly thinking about having sex.
39. The main thing which affects the sexual aspects of my life is what I myself do.
40. I'm very alert to changes in my sexual desires.
41. It's really important to me that I involve myself in sexual activity.
42. I usually worry about the sexual aspects of my life.
43. I do not hesitate to ask for what I want in a sexual relationship.
44. I feel unhappy about my sexual relationships.
45. The sexual aspects of my life are largely a matter of (good or bad) fortune.
46. I'm concerned about how the sexual aspect of my life appears to others.
47. I don't have very much fear about engaging in sex. (R)
48. My sexual relationship is very good compared to most.
49. I would be very confident in a sexual encounter.
50. I think about sex the majority of the time.
51. My sexuality is something that I myself am in charge of.
52. I am very aware of my sexual tendencies.
53. I strive to keep myself sexually active.
54. I feel nervous when I think about the sexual aspects of my life.
55. When it comes to sex, I usually ask for what I want.
56. I feel sad when I think about my sexual experiences.
57. The sexual aspects of my life are a matter of fate (destiny).
58. I'm concerned about what other people think of the sexual aspects of my life.
59. I'm not very afraid of becoming sexually active. (R)
60. I am very satisfied with the sexual aspects of my life.
61. I responded to the above items based on:
 - (A) A current sexual relationship.
 - (B) A past sexual relationship.
 - (C) An imagined sexual relationship.

Appendix H

Childhood Trauma Questionnaire

Please respond to each item with one of the following options by clicking the appropriate circle:

Items are rated on a 5-point scale, with responses ranging from Never True to Very often True

1	2	3	4	5
Never True				Very Often True

When I grew up...

1. I didn't have enough to eat
2. I knew that there was someone to take care of me and protect me
3. People in my family called me things like "stupid," "lazy," or "ugly"
4. My parents were too drunk or high to take care of the family
5. There was someone in my family who helped me feel that I was important or special
6. I had to wear dirty clothes
7. I felt loved
8. I thought that my parents wished I had never been born
9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital
10. There was nothing I wanted to change about my family
11. People in my family hit me so hard that it left me with bruises or marks
12. I was punished with a belt, a board, a cord, or some other hard object
13. People in my family looked out for each other
14. People in my family said hurtful or insulting things to me
15. I believe that I was physically abused
16. I had the perfect childhood
17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor or doctor
18. I felt that someone in my family hated me
19. People in my family felt close to each other
20. Someone tried to touch me in a sexual way, or tried to make me touch them.
21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them.
22. I had the best family in the world
23. Someone tried to make me do sexual things or watch sexual things
24. Someone molested me

- 25. I believe I was emotionally abused
- 26. There was someone to take me to the doctor if I needed it
- 27. I believe that I was sexually abused
- 28. My family was a source of strength and support.

Appendix I

Demographic Questions

In the box provided please indicate your age. _____

Are you currently in an exclusive romantic relationship?

- a. Yes
- b. No

If yes, please indicate how long have you been in your relationship? _____

Are you an international student?

- a. Yes
- b. No

Please indicate what year you are in school.

- a. Freshman
- b. Sophomore
- c. Junior
- d. Senior
- e. Senior +
- f. Graduate Student
- g. Other _____

In the blank provided please write your major. _____

In the blank provided, please indicate your gender. _____

In the blank provided, please indicate your sexual orientation. _____

Which ethnicity do you identify as?

- a. Caucasian/White
- b. African American/Black
- c. Asian American/Asian
- d. Hispanic/Latino(a)
- e. Native American/American Indian

- f. Bi-racial
- g. Other _____

When you were a child (prior to the age of 18), did anyone ever try or succeed in having any kind of sexual relations with you when you didn't want to?

- a. Yes
- b. No